HOSPICE CHAPLAINS USING CHRISTIAN SYMBOLS WITH CHRISTIAN END-STAGE DEMENTIA PATIENTS: TOWARD BEST PRACTICES OF SPIRITUAL CAREGIVING

A Dissertation

Presented to

the Faculty of the

Claremont School of Theology

In Partial Fulfillment

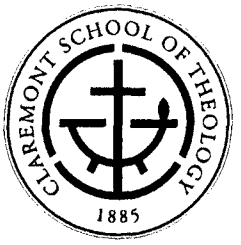
of the Requirements for the Degree

Doctor of Philosophy

by

Kevin Arthur Wardlaw

May 2015



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has been presented to and accepted by the
faculty of Claremont School of Theology in
partial fulfillment of the requirements of the

DOCTOR OF PHILOSOPHY

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May 2015

ABSTRACT

HOSPICE CHAPLAINS USING CHRISTIAN SYMBOLS WITH
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TOWARD BEST PRACTICES OF SPIRITUAL CAREGIVING

Kevin Arthur Wardlaw

This dissertation develops practical theological understandings in response to the following two research questions: What are best practices for hospice chaplains using Christian symbols with dementia patients? What do hospice chaplains learn from using Christian symbols with dementia patients? In order to address these questions, it is necessary to gain insights into the relationships between Christian symbolism and transcendence. For this study, transcendence is defined as "the state of awareness that dementia patients experience when they connect with Christian symbols in ways that allow them to reflect anew the image of God." The dissertation uses the Imago Dei construct of the Doctrine of Creation.

Hospice dementia patients generally cannot verbalize more than six-word sentences or engage in "meaningful" conversations. Establishing meaningful communication with them presents spiritual caregivers with significant challenges. Therefore, studying dementia patients directly would be a very difficult process. For this dissertation, I conducted interviews with three hospice chaplains who work with dementia patients at Hospice of Dayton and use Christian symbols in caring for them. Analyzing the interview data, I explore the themes that emerged during the chaplains' use of symbols in order to provide understandings of their best practices and discoveries which may guide future research. It is my hope that this study will help both hospice

chaplains and the Church respond more faithfully and responsibly in caring for these often marginalized children of God.

ACKNOWLEDGEMENTS

First and foremost, I want to thank God for making this dissertation possible and for guiding me in its development. The Rev. Dr. Ronald Glenn, former pastor of Wayman Chapel AME Church in Dayton, Ohio, once told me, "You're not doing your Ph.D. only for yourself." Those words reverberated with me during countless hours alone leading up to and including the writing of my dissertation. There are many people, including Dr. Glenn, who have a stake in this study and for them I am truly grateful.

I would first like to thank my dissertation committee members, Rev. Dr. K. Samuel Lee, Rev. Dr. Duane Bidwell, and Dr. John Sweeney. Their encouragement and insights were indispensable to my completing my work. I also would like to thank my thesis secretary, Dr. Mark Bilby and my proofreader, Rev. Dr. Vicki Wiltse who both played major roles in guiding me to my final draft. My first M.Div. course in 1997 was "Ministry with Older Persons," taught by Rev. Dr. John Jorgenson of Lutheran Theological Seminary in Philadelphia. He, along with Rev. Dr. William Clements of Claremont School of Theology, inspired and supported me in honing my skills in working with older persons and developing an appreciation for ministering to them. I would like to thank them both.

I would be remiss if I did not thank the library staffs of both United Theological Seminary in Dayton and the University of Dayton for opening their doors to me. They each allowed me access to valuable academic resources. I would like to thank Nate Payton of United for all of his I.T. support. I thank my colleagues at Hospice of Dayton, including John, Karen, Molly, Doris, Gayle, Lisa, and Mary, who were in my corner every step of the way. The cooperation of patients and their caregivers who participated

in this study was indispensible to my completing this work. I would also like to thank the ministerial staff and parishioners of Wayman Chapel for their support and encouragement along my journey.

I thank my brothers and sister, along with my daughters, Jennifer and Jocelyn, for their prayerful support.

Finally, I would like to thank the love of my life, Nevada, for her encouragement, support, advice, and love while I worked on my dissertation. Her love of older persons is both infectious and inspiring.

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To the loving memory of my mother, Marie, who lived with dementia,

and my father, Bill, who cared for her

CHAPTER 1

Introduction

With dementia-related illnesses rapidly growing worldwide, it behooves the healthcare industry and society at large to explore new ways to improve the quality of life for those who are experiencing this dreaded illness and their caregivers. Without doing so, the risk is run of even further marginalizing the already marginalized of the marginalized. As a hospice chaplain for over eight years, I have noticed that, among some of my patients with end-stage dementia, something often seems to click whenever I engage in God-talk. For the purposes of this dissertation, *God-talk* refers to any verbal references to God made by hospice chaplains when communicating with their dementia patients.

Even in cases where my patients have been sitting slumped over in their wheelchairs, once they become the least bit alert they manage to acknowledge that God loves them. This often is the case when I simply ask them, "Do you know that God loves you?" Their acknowledgement tends to be characterized by either a simple, "Yes," an affirmative head nod, or a verbal reference to God. It is as if they, in spite of their memory declines, are still acutely aware that God has not forgotten them. This acknowledgement, coupled with the fact that dementia patients often continue to be able to read well into their disease process, peaked my curiosity about how some level of visual stimulation might help them to engage in meaningful communication and experience subsequent transcendence. My operational definition of *transcendence* is *the state of awareness that dementia patients experience when they connect with Christian symbols in ways that allow them to reflect anew the image of God.*

I have two personal underlying motivations for doing this study. First, my mother

lived with dementia toward the end of her relatively short life of 74 years. Second, as a child, my friends and I used to make fun of "crazy old ladies." In our ignorance, we did not know that these children of God were struggling with an illness. Dementia is not only a mystery to most people but also to the healthcare industry. Thus, this study is both a commemoration of my dear mother and a sort of penance for my childhood antics.

The purpose of my qualitative research was exploratory in nature and, therefore, I did not aim for data saturation or generalizability. This study involved chaplains from Hospice of Dayton who presented dementia patients with various Christian symbols in order to help stimulate their spiritual memories. These hospice chaplains' showing of symbols to dementia patients forms a symbolic ritual. In addition, I contend that the symbolic power of the chaplain participants' caring presence can only be enhanced by their ability to help dementia patients create moments of meaning which continue to inform the expression of their Christian faith, thereby leading to their transcendence. Perhaps the proof of this rests in the observation that, despite all the memories which are forgotten, dementia patients often remember and understand religious symbols, suggesting that these symbols continue to embody some degree of normative power in helping them continue to live out their faith, albeit in new and transformative ways.

This dissertation employs Larry Graham's theological notion of "the image of God" or *Imago Dei.*[1] While Graham avowedly addresses his practical theological concerns to caring for the gay and lesbian community, I believe that end-stage dementia patients share a similar marginalization. Both groups of people have been pushed to the margins, not only in our social fabric, but within the healthcare industry as well. Like

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[1] Larry Graham, *Discovering Images of God: Narratives of Care Among Lesbians and Gays* (Louisville, KY: Westminster John Knox Press, 1997), 145.

Graham, I believe that "the concept of Imago Dei is one of the clearest symbols used in Christian teaching about what it means to be fully human."[2] Graham builds his practical theology through the integration of various aspects of the Imago Dei. According to Graham, the Imago Dei gains its substantive quality by considering it from the perspectives of the fullness of humanity and relationality or community. In this way, he believes that Christians can more powerfully reflect the image of God.

From my theological reflection with respect to caring for dementia patients, I too subscribe to Graham's notion of the fullness of humanity and that we are in relationship with one another. Dementia patients, like all of us, are whole persons or full human beings made in the image of God. They, along with non-dementia individuals, are growing into that image. I hold that chaplains using Christian symbols can help dementia patients develop into the Imago Dei. In turn, these children of God more magnificently reflect God's image while also reconnecting with their faith. When this occurs, the chaplains aid their dementia patients in their transcendence primarily because, relationally speaking, the ritual of their caring presence is augmented by their use of Christian symbols. Thus, this dissertation is more directly concerned about how chaplains can best care for their dementia patients using Christian symbols rather than simply studying the effects this intervention has on patients. Therefore, how the chaplains use the symbols in establishing best practices is of paramount importance. Through this research, I hope to provide a deep understanding of what the chaplains in this study learned.

It is my belief that as dementia patients grow into the Imago Dei, they experience

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[2] Ibid., 147.

an awakened awareness of God's presence. I believe the patients' rekindled awareness of God's presence manifests in their abilities to both verbally and nonverbally articulate an awareness of this divine presence. The verbal articulation of their awareness is not necessarily accomplished through God-talk, but it is often expressed by their deep longings to be in community with others. I believe their tendency to want to experience the sensation of touch bears witness to this claim. For many marginalized dementia patients, their relationships with their chaplains creates a sense of community. This is so because, if even for a few moments, the chaplains' spending time helping their patients rekindle their spirituality through Christian symbols forms a strong sense of communal belongingness on the part of the patients. Given the potential Christian symbols have for reigniting and expressing the deep faith of dementia patients, it behooves the academy to try to understand what good chaplaincy practices look like in such scenarios. Perhaps then both chaplains and the academy may learn how to more faithfully and responsibly care for dementia patients.

Dementia comes in various forms. Two of the most common forms are vascular dementia and Alzheimer's disease. According to the DSM-5, both are considered major neurocognitive disorders. Vascular dementia is generally a neurocognitive disorder that results from other illnesses, such as strokes, whereas Alzheimer's dementia is an organic brain disease. Dementia is a group of symptoms as opposed to a specific disease. It is characterized by impairments in thinking, remembering, and reasoning. In terms of the types of dementia listed in the DSM-5, three of the patients in this study were diagnosed with vascular dementia, two with Alzheimer's disease, and one with dementia symptoms attributed to congestive heart failure. According to Medicare hospice guidelines, end-

stage dementia patients generally cannot verbalize more than six-word sentences or engage in "meaningful" conversations. I believe that some degree of meaningful communication is a prerequisite condition for such patients to be able to noticeably reconnect with their faith and experience transcendence.

Establishing meaningful communication with dementia patients presents spiritual caregivers with significant challenges. Since they holistically treat end-stage dementia, hospice chaplains can be thought of as frontline responders. When dementia patients are alone, which happens far more times than it should, chaplains provide momentary opportunities for these patients to feel loved and cared for. Given the powerful impact chaplains can have on increasing the quality of their dementia patients' lives, every effort should be made to provide them with as many tools as possible to foster such quality-of-life improvements. Using Christian symbols is one such tool.

The behaviors of three chaplains captured through my interviews with them and through other data are analyzed thematically. The dissertation was originally conceived as a case study. However, as the project progressed, the inherent limitations in working with dementia patients made data collection challenging. Through discussion with my faculty committee, I decided to use various kinds of collected data and to apply a thematic analysis. The chaplains' clinical note summaries were part of the collected data (see Appendix A). In order to place the chaplains' behavior in context, some of the effects of their interventions were also analyzed by thematic coding. The coded clinical note summaries were then used to formulate the specific questions for the first interviews with the chaplains. Additional follow-up interviews with three chaplains were conducted in December 2014. Themes or patterns were then identified and used to shed light on

both what chaplains' best practices using Christian symbols with their dementia patients looked like and what the chaplains learned in the process.

As already discussed, my research involved three hospice chaplains who serve at Hospice of Dayton. They each showed various types of Christian symbols to two Christian dementia patients over the course of two visits per patient. This work spanned a five-month period beginning in March 2014 and concluding the following August. The symbols used fell into one or more of five categories. These categories were Jesus' nativity, crucifixion, and resurrection and the sacraments of baptism and the Lord's Supper. The rationale for using these five symbol categories is that they are common to most expressions of the Christian faith and therefore would have a higher chance of being recognized than other Christian symbols.

All of the chaplains were Christian. Two of them were female and one was male. One of the females was African-American. The remaining chaplain participants were Caucasian. All of them were middle-aged. The criteria used for selecting the patients was that they should be in the beginning stages of end-stage dementia. The rationale for this criteria was that, in this stage, there was a greater probability that these patients would be responsive. Given that the focus of the study is on chaplains' behaviors, the patients served only as secondary participants. They were secondary in the sense that they were instrumental in allowing the chaplains' behaviors to be studied.

The following additional definitions of key terms are used in this study. *Spirituality* or *spiritual* refers to any human expression that is characterized by a deep sense of meaning and purpose. In the case of this study, such a notion of spirituality or spiritual was evidenced through patients' associations with specific types of "Christian

symbols." When I use the word *religious*, I am referring to faith-authorizing stances or subscriptions that help organize and articulate an individual's spirituality. *Christian symbols* are physical depictions of the five previously described symbol categories. *Sacred* refers to the divine, and *ritual* refers to specific sets of practices associated with a particular religion, in this case Christianity.

This study is a practical theology research endeavor. John Swinton and Harriet Mowat define practical theology as being "dedicated to enabling the faithful performance of the gospel and to exploring and taking seriously the complex dynamics of the human encounter with God."[3] My research explores best practices for chaplains to faithfully perform the gospel when encountering the complexities of spiritually caring for dementia patients. Various types of collected data are analyzed thematically. Thematic analysis is one of the most common data analysis methods in qualitative research. It "is a method for identifying, analysing and reporting patterns (themes) within data."[4] The themes designate various analysis categories or codes, and thematic analysis is performed through coding in six phases. The phases are "familiarizing yourself with your data," "generating initial codes," "searching for themes," "reviewing themes," "defining and naming themes," and "producing the report."[5]

With thematic analysis, the researcher identifies ideas and patterns within data sets. The interpretation of the codes generated through this process includes comparing theme frequencies, identifying theme co-occurrences, and visually displaying

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[3] John Swinton and Harriet Mowat, *Practical Theology and Qualitative Research* (London: SCM Press, 2006), 4.

[4] Virginia Braun and Victoria Clarke, "Using Thematic Analysis in Psychology," *Qualitative Research in Psychology* 3, no. 2 (2006): 79.

[5] Ibid., 87.

relationships between various themes. Thematic analysis lends itself to analyzing interviews. This form of analysis can be done either inductively or deductively. Inductive thematic analysis is data-driven, while deductive thematic analysis is theory-driven. Effective themes are able to shed light on the *big picture*. The themes of thematic analysis are either semantic ones designed to identify surface meanings of data or latent themes that provide more in-depth understandings. It is important to note that there is a distinction between a theme and a code; a theme results from multiple codes. Researchers utilizing the thematic analysis method maintain reflexivity journals in order to keep notes that they can later use in interpreting their data.

There are inherent advantages and disadvantages to using thematic analysis. For the purposes of this research project, perhaps the biggest advantage to using thematic analysis lies in the tendency for categories to emerge from the data. Its primary disadvantage is its perceived lack of reliability. Thematic analysis's reliability is often a concern due to the wide assortment of thematic interpretations that can arise; therefore, generalizability is limited. Practical theology is an interpretive enterprise, and this research is an interpretive study that allows deep meanings to emerge from the data. The aim of this study is not to seek the generalizability of being applicable to all dementia patients. Rather, it is to interpret three chaplains' understandings and experiences with their respective dementia patients.

I employ Richard Osmer's four tasks of practical theology research as an organizing structure for this study.[6] These four practical theological tasks are overlapping tasks. They are the descriptive-empirical task, the interpretive task, the normative task,

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[6] Richard Osmer, *Practical Theology: An Introduction* (Grand Rapids, MI: William B. Eerdmans Publishing, 2008), 4.

and the pragmatic task. These tasks do not exist discretely, but often exist simultaneously with one another. With the descriptive-empirical task, information is collected in order to help a researcher "discern patterns and dynamics in particular episodes, situations, or contexts."[7] Through the interpretive task, various theories are used to gain deeper understandings of why these patterns and dynamics are occurring. With the normative task, theological principles are used to explain or interpret specific episodes, situations, or contexts in order to build ethical standards or theological norms to shape our responses and determine what "good practice" looks like. Finally, the pragmatic task is characterized by ascertaining strategies that will affect situations in desirable ways, leading to reflective conversations resulting from the determined strategic implementations.[8] Osmer rephrases the essential understandings of these tasks by asking the following four questions:

1. What is going on? (descriptive-empirical task)
2. Why is this going on? (interpretive task)
3. What ought to be going on? (normative task)
4. How might we respond? (pragmatic task)[9]

Following this introductory chapter are four chapters. Chapter Two provides a literature review focused on rituals and Christian symbols as they relate to chaplains' work with dementia patients. This chapter is associated with Osmer's normative task. In Chapter Three, I engage in Osmer's descriptive task, keeping in mind that his four tasks overlap. The initial research questions (some of which were used in both rounds of interviews) and the follow-up conversations to the first set of interviews are explored. I describe in detail my research method and findings, examine the trustworthiness of my

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[7] Ibid.
[8] Ibid.
[9] Ibid.

study, and suggest the significance of my findings for the academy.

In Chapter Four, I engage in Osmer's interpretive task. In view of my literature review and findings, the essential question addressed here is, "How do I interpret the data in such a way as to gain a deep understanding of chaplains' best practices and discoveries associated with using Christian symbols with end-stage dementia patients?" I will briefly discuss the effects the chaplains' interventions had on their patients in order to place the chaplains' behaviors in context. However, the intervention effects will be subordinate to understanding the chaplains' behaviors.

Finally, in Chapter Five, I present my conclusions. I summarize my dissertation's methods and findings and then engage in Osmer's pragmatic task. The essential questions I seek to answer are, "What should chaplains and the Church do to spiritually care for people suffering from dementia?" and, "How do they do so faithfully and responsibly?"

CHAPTER 2

The Normative Task: Literature Review

In this chapter, I will perform Osmer's normative task through providing a review of literature relevant to this study. Establishing what should happen when chaplains use Christian symbols with dementia patients is done by engaging the literature through several lenses. I will examine the most salient scholarship concerning the relationships between Christian narrative and dementia and then consider various ritual implications with regard to this major neurocognitive disorder. The chapter will conclude by focusing on the interplay between the use of Christian symbolism and a practical theology of dementia care.

The Christian Story and Dementia

The historical events of the Christian tradition are at the core of the Christian narrative. The specific events or markers that form the uniqueness of Christianity are found in the birth, death, and resurrection of Christ. Therefore, Jesus' nativity, crucifixion, and resurrection have historical value; their symbolic meaning is even greater. As H. Richard Niebuhr suggests, there is a distinction between these historical events and the sacred stories surrounding them. He contends that for the revealed meaning of the faith, there must be a coming to terms of the two. According to Niebuhr, " . . . the history to which we point when we speak of revelation is not the succession of events which an uninterested spectator can see from the outside but our own history."[1] Along with these historical and sacred events are the sacraments of the church. Two of the Christian

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[1] H. Richard Niebuhr, "The Story of Our Life," in *Why Narrative?: Readings in Narrative Theology*, edited by Stanley Hauerwas and L. Gregory Jones (Eugene, OR: Wipf and Stock Publishers, 1997), 29.

sacraments that are found in almost every expression of Christianity are baptism and communion. I believe that both these historically sacred events and these two foundational sacraments form the basis of Christian ritual. I make this claim because these events and sacraments are affirmed and practiced in practically all Christian groups. In other words, from my perspective, these events and sacraments are common to any church that claims to be Christian. Connected to both are the events and acts themselves and the symbolic meaning(s) attached to them. I further assert that these rituals have the power to help believers remember the sacred past, both universally and personally. In the case of dementia patients, these symbolic rituals have the power to help them remember the sacredness of Christianity and of their own historical expressions of it.

With respect to my research questions concerning best practices and chaplains' learnings related to using Christian symbols with dementia patients as it relates to transcendence, I believe that chaplains must consider some characteristics of patients' stories. Chaplains must first realize that even with limited, few-word responses to the symbols, patients are not simply relating to chaplains on the basis of their mundane accounts of the ordinary events of their lives. Patients likely are not even aware of the sacredness in their mundane responses. For example, after observing a symbol of Christmas, through my prompting, one of my patients stated that one of her favorite Christmas gifts was a doll. On one level, the patient, with her flat affect, may not even realize how significant her response was on a conscious level. However, on a spiritual level, her ordinary perception of the event can ritually transport her from a momentary mundane existence to one that is indeed sacred. In this regard, which symbols chaplains use, the order in which they use them, the number of different types of symbols they use,

and the degree of prompting utilized can play a significant role in helping their patients experience transcendence. Before chaplains try to determine the shape of best practices with dementia patients, they need to take into account the embedded or latent sacredness within patients' stories. Therefore, one thing learned by chaplains is that these unrealized patient story meanings are paramount in spiritually caring for their dementia patients.

In order for chaplains to fashion their best practices with their patients and gain subsequent discoveries, it is important for them to understand the difference between "sacred" and "mundane" stories.[2] I believe this gives chaplains a solid basis for placing patient responses to Christian symbols in context. Stephen Crites describes the difference between sacred and mundane stories. In his scheme, embedded within sacred stories is a sense that the symbolic worlds they represent are dwelling places. It is in these stories that people are able to witness the ebb and flow of their own behaviors. Crites refers to these fundamental stories as "sacred stories" because in them people are able to learn something about themselves and the world they inhabit.[3] According to Crites, all stories are mundane ones, including sacred stories, as a result of their attention to objectivized images associated with words, scenes, roles, and plot sequences.[4]

I contend that there is a Critean dimension to dementia patients' stories. Within the stories of their lives is an account, often no longer known to them as a result of their illness, of their everyday mundane existence. However, dementia patients are no longer capable of remembering much of these mundane stories on a conscious level. However, I

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[2] Stephen Crites, "The Narrative Quality of Experience," in *Why Narrative?: Readings in Narrative Theology*, edited by Stanley Hauerwas (Eugene, OR: Wipf and Stock Publishers, 1997), 69.

[3] Ibid., 70.

[4] Ibid.

assert that they are quite capable of remembering some or parts of their sacred stories on deeper spiritual levels. Even momentarily, they are able to present a spark of themselves and their relationship to the world they have and continue to inhabit. I submit that this spark is the power and presence of the Holy Spirit, which has the power of allowing them to reconnect with their faith.

Crites presents the notion of a mediating story form which bridges sacred stories and mundane ones. He claims that this mediating story form is the experiencing consciousness. Referencing the work of Immanuel Kant, Crites states, "Consciousness has a form of its own, without which no coherent experience at all would be possible."[5] With regard to dementia patients, chaplains caring for them can often become frustrated by the fact that within the conscious minds of the patients there are disconnects that alienate them from both their mundane and sacred stories. However, borrowing from Kant, I believe that attuned chaplains can reach beyond their patients' conscious minds and tap into their unconscious ones through the use of Christian symbols. My research bears some witness to this phenomenon in that dementia patients who were otherwise confused expressed some degree of clarity while viewing Christian symbols.

In developing best practices for using Christian symbols with dementia patients and arriving at subsequent discoveries, chaplains should be aware of some of the powerful connections between story and ritual. Johann Baptist Metz cites the work of Martin Buber in shedding light on some of the practical and performative aspects of narrative. In Buber's discussion of Hasidic stories, he argues that "the story is itself an

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[5] Ibid., 72.

event and has the quality of a sacred action."[6] With regard to my dissertation, I assert that the Christian story is a series of historical and sacramental events that take the form of symbolic ritual. As the chaplains show patients Christian symbols, thereby telling the Christian story, the very act of them doing so can be seen as their performing a sacred and symbolic ritual. It has the effect of creating a story within a story, where the innermost story is the patients' response to the larger Gospel story. It is my belief that some fundamentalist interpretations have become so dogmatic that they have restricted the living word of God in Scripture and taken some of its life from it. For Scripture to be truly living, its meaning should be deep and broad enough to allow for the incorporation of contemporary social and cultural hermeneutics. Jerome Berryman's Godly Play methodology, which uses concrete materials to creatively tell stories, is one such way to broaden and enliven the Biblical narrative. Episcopal minister Lois Howard has adapted Godly Play into an approach that helps caregivers meaningfully communicate with persons living with dementia through storytelling and creative and artistic activities.[7] My own experience with some dementia patients is that pretending is a meaningful way to communicate with them.

For chaplains working with dementia patients, every measure should be taken to gather collections of symbols that are familiar to all Christians. For example, some degree of care in showing Christian symbols to Protestant dementia patients should be

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[6] Johann Baptist Metz, "A Short Apology of Narrative," trans. David Smith, in *Why Narrative?: Readings in Narrative Theology*, edited by Stanley Hauerwas (Eugene, OR: Wipf and Stock Publishers, 1997), 253.

[7] Lois Howard, "Discovery to Recovery: Godly Play for Alzheimer's Patients," Virginia Theological Seminary Key Resources, posted on February 3, 2014, http://www.keyhallonline.org/profiles/godly-play-discovery-recovery (accessed December 6, 2014).

taken by considering the possible exclusiveness of utilizing symbols that are characteristically associated with Catholicism. The degree to which chaplains embrace inclusivity in showing inviting symbols can determine the degree of their effectiveness in meaningfully and ritually connecting with their patients in transformative ways. Again, chaplains' desire to do so is what fuels their willingness to use creative interventions, such as symbolism, to reach their patients. Best practices for chaplains using Christian symbolism and making discoveries with dementia patients should take symbol inclusiveness into account.

I believe there needs to be a sense of what God is revealing to both chaplains and dementia patients embedded in the chaplains' use of Christian symbols in order to arrive at best practices and discoveries. For Christian symbols to have any effect in stimulating patient transcendence, they must have the potential to say something about what God wants dementia patients to know about God. John Barton believes that stories have the potential to teach us something about the revelation of God.[8] The revelation of God, simply put, is what God wants us to know about God's self. Barton believes that story accomplishes this by showing us who we are in relation to the problems we face in encountering this world.[9] While there is clearly truth in this claim, I believe that Barton has not gone far enough. I would contend that story not only has the power to show us who we are, but conversely, it is capable of showing us who we are not. It is not sufficient for coming to terms with what God wants us to know about God's self to know

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[8] John Barton, "Disclosing Human Possibilities: Revelation and Biblical Stories," in *Revelation and Story: Narrative Theology and the Centrality of Story*, edited by Gerhard Sauter and John Barton (Burlington, VT: Ashgate Publishing Company, 2000), 54.

[9] Ibid., 54.

what we should do in any given situation; it is even more telling if and when we know what we should not do in a given situation.

As chaplains use Christian symbols with dementia patients, both patients and chaplains are exposed to the possibility of learning more about themselves. Patients who have not been in church for years and who no longer remember its rituals and meanings can, upon viewing a symbol of a crucifix, state simply the name, "Jesus," when asked who is on the Cross. I submit that they can do this without understanding why Jesus was on a cross or what the Cross represents. However, their being able to correctly identify Jesus gives chaplains glimpses into the nature of their long-term religious memories. Similarly, chaplains can learn about the quality of their witness in terms of how patient, nonjudgmental, and agenda-free they are with their dementia patients.

I believe that one of the best practices and related discoveries for chaplains using Christian symbols with dementia patients is found through the chaplains guiding patients during their interactions with them. How chaplains use Christian symbols to help dementia patients share parts of their faith stories is often done through prompting. I believe that prompting can help patients not only purely recognize some symbols, but it also can help them save face enough to take a chance in sharing and perhaps reliving some of their faith stories. The motivation for using prompting is caring chaplains' desire to meaningfully and ritually help their patients reconnect and transcend. As chaplains are able to accomplish this, they, too, may find themselves being ritually transported to sacred places that both they and their patients momentarily share. The possibility of mutual transcendence can thus help form the basis of chaplains' best practices of using Christian symbolism with their patients. In turn, such a degree of chaplain transparency is

likely to help chaplains learn more about themselves.

Some understanding of hermeneutics is necessary for chaplains to arrive at best practices and discoveries through using Christian symbolism in dementia care. Even though dementia patients' cognitive abilities are diminished, there often remains a capacity, whether cognitive or spiritual, that allows them to make some sense of the symbols they are being shown. My research repeatedly shows that some dementia patients both verbally and nonverbally connect with Christian symbols. Hans Frei borrows from the work of Barth to present the three descriptive elements and stages of hermeneutics.[10] These three stages are believed to be interrelated. In summary, the first stage, or *explicatio*, is characterized by the retelling of the story or other texts. It is followed by the *meditatio*, which is the conceptual re-description of the story or other texts. In other words, it refers to the refraction of the text through the structures of the mind. Finally, the *applicatio* stage is characterized by the ability to relate the story or other texts to their context. I believe that this construct, while explaining how hermeneutics is generally done, is limited in the case of studying how dementia patients are able, in some situations, to understand the story of their faith. Given their significant cognitive limitations and diminishments, one could argue that they should not be able to understand the sacred meaning of the Gospel story. However, I believe that there exists a way of understanding or a hermeneutics that transcends typical cognitive abilities. This, I have found, is often characterized by the fact that Christian symbols and their accompanying God-talk are the primary means by which the patients become engaged. Thus, knowing something about how dementia patients might interpret Christian symbols

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[10] Hans Frei, *Theology and Narrative: Selected Essays*, edited by George Hunsinger and William Placher (New York: Oxford University Press, 1993), 113-114.

is helpful to chaplains as they seek to determine best practices and understandings about how to symbolically care for their dementia patients.

Chaplains' best practices and discoveries should be informed by an understanding of the connection between theology and narrative. Related to the above discussion of patient hermeneutics, at some level, dementia patients do theology through a connection between the meanings of Christian symbols and narrative. Some patients in the study were able to take theological references to both historical events and sacraments and express unique personal stories around them. Michael Goldberg affirms Hans Frei's assertion in *The Eclipse of Biblical Narrative*, stating that ". . . to take the structural shape of biblical narrative seriously is to take it as the shape of reality."[11] Such a statement then implies that the structural shape of biblical narrative reflects the shape of reality. I take issue with this implication because I believe that a fundamental question is, "From whose perspective is a sense of reality determined?" Another implication here is that reality is universal. What is real for one is real for all. However, I submit that reality is not universal, but unique to each individual. What is real for one is not necessarily real for all.

Take the case of dementia patients. The cognitive effects of their illness have altered their sense of reality. For example, it is quite possible that dementia patients, who might have been avid readers earlier in their lives, could have disease progressions that have left them no longer able to recognize a book for what it is. While it is still a book in a commonly accepted sense of reality, from their perspective of reality, it may no longer be a book. Likewise, an act or ritual of eating could also lose its meaning to the point that, from some dementia patients' perspectives, their reality of eating is foreign to that of the

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[11] Michael Goldberg, *Theology and Narrative: A Critical Introduction* (Philadelphia: Trinity Press International, 1991), 162.

general population. Therefore, when dementia patients view the Christian symbol of a crucifix, it could evoke sadness without any conscious awareness on their part of the basic elements of the symbol. While they may not be able to identify the Cross as being such, the symbol has somehow reached into their religious/spiritual memories, and they have sensed that a person hanging on some wood is not only cruel but sad as well. It is in this vein that I argue against Frei's and Goldberg's assumption that the structural shape of biblical narrative reflects the shape of reality.

While chaplains' showing Christian symbols to dementia patients can be seen as ritual acts in and of themselves, Christian symbols can also represent rituals. For example, in most practices or portrayals of communion, food or a meal is the centerpiece. In this case, within the ritual of showing the symbol is another ritual that I assert has the power to tap into dementia patients' spiritual memories. In such situations, dementia patients might no longer be able to identify and articulate the spiritual dimensions of communion. However, they may be very much in tune with the intimacy that often is shared around food, such as is frequently found in family gatherings. In both the case of an alternative ascription to a crucifix and the meaning of communion, the Biblical narrative undergirding them is fully intact, despite the altered realities of some dementia patients.

I contend that there is another sense in which the structural shape of biblical narrative does not reflect the shape of reality. This is apparent in the case of Jesus' parables. What is most important about these parables is not the accuracy of their literary or historical details. Instead, what is most significant is the accuracy or truth of the lessons to be learned from the stories. In the case of the parable of the Good Samaritan, its details are subordinate to its truth claims. Whether this story ever actually took place

in history is somewhat irrelevant. What is relevant is the truth of the theme, which is that the love of an outsider in hostile circumstances reflects what a neighbor looks like more than the love of an insider toward another insider. In this sense, whether or not this event is history or fiction does not matter because the theme of the story is true. I believe that, as far as reality is concerned, many dementia patients are living out their own parables even when they have lost touch with a common sense of reality. Unique patient parables, in light of unique senses of reality, should thus be factored into chaplains' establishing best practices and meaningful understandings.

An understanding of the transformative power of the Beatitudes could help chaplains define their best practices and make discoveries. This is so because chaplains should be able to grapple with the often dichotomous relationships between patients' accounts of their stories, however limited, and God's understandings of them. John Navone refers to the Beatitudes as a way of God transforming the human story. He suggests that the Beatitudes' transformative power is grounded in our ability to reconcile "Jesus' radically different way of imagining human happiness . . ." with our own.[12] He further argues that the struggle for believers is that their images of their stories are in dynamic tension with God's sense of them. The root of this tension lies in the distinct and unique ways that people imagine their stories in contrast to the ways God does. God's story is centered on God's love as revealed in the life of Jesus Christ. From Navone's perspective, our sense of our stories often contradicts the Gospel story. This contradiction, he argues, is what often makes the Beatitudes confusing. Chaplains who are able to journey with their dementia patients through their theological confusion are in better

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[12] John Navone, *Seeking God in Story* (Collegeville, MN: Liturgical Press, 1990), 42.

positions to form effective practices and gain wider understandings from them than if they refrain from doing so.

Dementia patients' relating to the other, however vague the expression of that relating is, forms the basis of the transcendent power of chaplains using Christian symbols with them. Sometimes dementia patients, particularly early in their disease process, are able to recognize people, especially family members. Their recognitions of the type of connections they have to these others or family members are largely intact. However, as their disease processes advance, like it has for the patients in this study, their recognitions of intimate others are increasingly lost. Now a mother's spouse, son, or daughter is only viewed as someone with whom she can feel safe and loved. Chaplains showing Christian symbols to dementia patients should become part of the patients' communities of others as a way of shaping and refining their best practices and deepening their understandings of them. I assert that everyone, including dementia patients, need others, not only to become persons, but to become transcendent ones.

Furthermore, I believe that the transcendent power of Christian symbols depends on this notion, because transcendence can only be defined in relationship to our ability to relate to the other, whether consciously or not, in meaningful ways. This is also the case with dementia patients. Even in spite of their dementia, I believe, like Navone, that people define themselves by what they are seeking, "whether the goal be simply insight of a human kind or some transcendent ideal such as peace."[13] I assert that even in the most severe dementia cases, the patient's desire to transcend is grounded in this universal hope to experience lasting peace of mind, body, and soul. I believe this to be the case

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[13] Ibid., 57.

whether patients can verbally articulate this hope or not.

I have previously argued that dementia patients' sense of reality is relative due to their cognitive limitations. The symbol of a crucifix to one person might be literally and generically viewed as a piece of wood with a body hanging from it, with no subjective response to it. However, other patients might view the same crucifix as a symbol of hate and cruelty. Which one is true? In a literal sense, the answer is, both of them. Just as a Christian symbol evokes different responses, so does the Gospel story and other stories. On the subject of whether or not a "true" story exists, Tilley claims that ". . . an unsurpassable story . . . is beyond human capacity to hear or tell."[14] One can argue in favor of Tilley's claim on the basis that even the Gospel story varies some in the details of its narrative. Also, the truth of a parable lies in the truth(s) of its revealed meaning(s). As they develop their best practices and arrive at deep understandings of how to use them, chaplains approaching their dementia patients with Christian symbols should be comfortable with the notion that Biblical meaning is largely a matter of interpretation.

Ritual and Dementia Care

To the extent that showing Christian symbols to dementia patients is a ritual or reflects various Christian rituals, it behooves chaplains to understand something about the relationship between ritual and dementia. Chaplains in search of best practices and deep understandings of using Christian symbols with dementia patients need to consider the notion of ritual because of the ritual tendencies associated with this intervention. Therefore, let us now turn to the concept of ritual and its relationship to a practical theology of dementia care. According to Catherine Bell, ritual is a ". . . particular way of

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[14] Terrence Tilley, *Story Theology* (Collegeville, MN: The Liturgical Press, 1990), 212.

looking at and organizing the world."[15] Bell presents a transcendent aspect to the idea of ritual. She asserts, "Its various applications make clear the way in which the concept has mediated a series of relationships between 'us' and some 'other.'"[16] Ritual has its roots in religion. One of the debates associated with it are whether or not religion and culture have their roots in myth or ritual. Bell presents several schools of thought on this debate. The myth and religion school tends to view ritual as the origin of religion and culture. The phenomenologists of religion, on the other hand, focus on myth, and the psychoanalytic school focuses on both myth and ritual.[17] In this work, I am aligning myself with the myth and religion school. A summary of this school's perspective is as follows:

> The religions of ancient Egypt, Babylon, and Canaan were primarily ritual religions, centered on the dramatization of the death and resurrection of the king as a god in whom the well-being of the community rested. Essential to the ritual action was the recited story, which was deemed to have had equal 'potency'. Over the course of time, however, the actions and the story separated and gave rise to distinct religious and dramatic genres.[18]

Bell suggests that ritual is a basis for social transformation. However, I believe that it is also an agent for personal transformation. More will be said about this later. My work with hospice dementia patients and other hospice chaplains bears witness to this point. In many cases, patient responses in the context of chaplains' showing Christian symbols to them can be seen as ritual behavior in the sense that these are practices that help dementia patients transcend. If, even for a moment, some patients are able to step

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[15] Catherine Bell, *Ritual: Perspectives and Dimensions* (New York: Oxford University Press, 1997), ix.

[16] Ibid., xi.

[17] Ibid., 3.

[18] S. H. Hooke, "Introduction," in *The Labyrinth: Further Studies in the Relation between Myth and Ritual in the Ancient World*, edited by S. H. Hooke (London: Society for Promoting Christian Knowledge, 1935), v-vi.

beyond the stupor associated with their illness into remembering something sacred in their pasts, this is significant. In one instance shared in this dissertation, the symbols of the Nativity or Christmas as well as those of the Cross or baptism evoked a one-word response. Somehow, the holiness of the symbol was able to reach into the religious memory of a 97-year-old dementia patient, helping her to simply state the word, "Jesus." I believe that this one-word response was a reflection of something she held sacred in relation to these iconic symbols attached to the Christian tradition.

I believe that, in the case of the patients and chaplains studied in this dissertation, there is a two-part dimension to the ritual of using these Christian symbols. The first dimension is the ritual benefit attached to the chaplain and the patient responding to the symbols. I believe that not only do patients have the potential to experience transcendence, but chaplains do as well. Unbeknownst to many chaplains is the process of their being taken from performing some of the daily rituals of their jobs to a divine world of spiritually caring for the other. I further assert that when chaplains are able to tap into their missions on a spiritual level, what can be seen as simply performing the activities of their job descriptions can, at the same time, be viewed as their carrying out their divine charges to assist in helping to make disciples of their neighbors.

Rituals fall into various categories. Bell offers two categories germane to this dissertation's thesis. Specifically, she refers to a type of rite associated with the human life cycle, which ". . . links generations and roots the value system with people's most intimate experiences of living and dying."[19] The second type of ritual presented by Bell is associated with rites of exchange and communion. According to her, such rites "help

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[19] Bell, *Ritual*, 136.

articulate complex systems of relationships among human beings [and] gods."[20]

According to Bell, there is an inherent sacred symbolism and transcendence embedded within ritual. She asserts that "activities that explicitly appeal to supernatural beings are readily considered to be examples of ritual."[21] Bell claims that the extent to which communal activities and other activities that adhere to the divine are ritualized determines whether or not ". . . participants suggest that the authoritative values and forces shaping the occasion lie beyond the immediate control or inventiveness of those involved."[22] With respect to the hospice chaplains studied and their dementia patients, I believe that there exist spiritual forces at work that are beyond the patients' abilities. Bell captures the transcendence of this divine ritual:

> Fundamental to all the strategies of ritualization examined is the appeal to a more embracing authoritative order that lies beyond the immediate situation. Ritualization is generally a way of engaging some wide consensus that those acting are doing so as a type of natural response to a world conceived and interpreted as affected by forces that transcend it – transcend it in time, influence, and meaning . . .[23]

While the chaplains studied were performing the rituals of showing Christian symbols to their patients and were clearly actors in this ritual as alluded to earlier, the patients themselves can be seen as actors as well. They are actors in the sense that both their verbal and nonverbal engagement with the symbols can be viewed as ritual acts. Thus, I claim that chaplains who are in tune with the transcendent power of rituals are better equipped to develop best practices and deeper understandings of them than chaplains who are not.

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[20] Ibid.
[21] Ibid., 155.
[22] Ibid., 169.
[23] Ibid.

Alternatively, in their book, *Christian Symbol and Ritual*, Bernard Cooke and Gary Macy present a unique discussion regarding the interplay between Christian symbol and ritual. They suggest that some of the characteristics of Christian symbols and rituals are those associated with power, ambiguity, and uniqueness. Though the authors tend to use the terms *symbol* and *ritual* synonymously, a distinction among them is implied in their presentation. Essentially, they suggest that symbols are signs, whereas rituals are acts. The word *ritual* is derived from the Latin *sacramentum* or "sacrament," which is another word for describing how, through the use of symbols or rituals, God "chose to mediate salvation to humans."[24] However, the authors claim that the term *sacrament* is often used by Christian insiders to connote a sense of power. Furthermore, both symbol and ritual have relative degrees of power depending on whether or not one is an "insider" or an "outsider."[25] Bearing this in mind, I argue that Cooke and Macy's insider-outsider classification is not complete enough because it fails to take into account that there are relative degrees of being an insider. For example, I assert that the power of high church clergy is often construed as being greater than that associated with low church leadership. Along these lines, how hospice chaplains present themselves in rituals with their dementia patients can be suggestive of power dynamics. I claim that chaplains dressed in traditional clerical garb can be perceived as being part of a more powerful ritual than chaplains who are secularly dressed. Do such perceived power differences affect the way dementia patients engage in chaplains' rituals? The answer to this question warrants further study.

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[24] Bernard Cooke and Gary Macy, *Christian Symbol and Ritual: An Introduction* (New York: Oxford, 2005), 38.

[25] Ibid., 20.

The notion of power becomes particularly important when considering ritual. According to Cooke and Macy, ". . . rituals are often understood to be one means of communicating the divine presence to the community . . . If the rituals depend on certain leadership roles, those roles (as opposed to the rituals) may eventually come to be seen to mediate the divine."[26] Insider descriptions of rituals and symbols tend to be more clearly defined than outsider ones. Where the divine is located plays a significant role in this regard. For example, is the risen Christ present in the community or only in scripture?[27] Concerning the uniqueness of rituals, they always occur in a real time and place and are never repeatable. As alluded to several times throughout this dissertation, the Christian symbols used by the chaplains in this dissertation treat the birth, death, and resurrection of Jesus as symbols in addition to the communal symbols of baptism and communion.

It is widely believed that Christian symbols not only celebrate salvation but also "give grace." In keeping with this aspect of Christian symbols, Cooke and Macy present five general elements of ritual. First, all rituals demonstrate how a community understands the world and how the ritual forms that understanding. Second, Christian rituals play a pivotal role in the spiritual formation of Christians. Third, Christians believe that the risen Christ is alive and present in their rituals. Lastly, every Christian ritual is intended to be one that celebrates friendship.

Cooke and Macy call for a holistic understanding of the power dynamics embedded in symbols and rituals. I tend to agree that it is important to examine symbolic and ritualistic power dynamics as they relate to developing a practical theology of ritually caring for dementia patients. However, I suggest that a more intentional examination of

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[26] Ibid., 22.
[27] Ibid., 23.

the powerless members of the Christian community be engaged in. For example, hospice dementia patients represent a unique sector of the body of disenfranchised members of the household of faith. As far as my research questions are concerned, an understanding of the potential disenfranchisement of some hospice dementia patients is necessary in order for chaplains to better understand what their best practices consist of and what they learn through employing them.

For chaplains to develop best practices and learn from them, it becomes important for them to gain some insights into the nature and quality of symbols and ritual behavior. Roy Rappaport views symbols in the context of language and meaning. According to Rappaport, "With the symbol an entirely new form of information . . . appeared in the world. This new form brought with it new content, and the world as a whole . . . has not been the same since."[28] Like Bell, Rappaport argues that both symbol and ritual allow for a transcendence beyond the here and now. Bell describes a sacral symbolism, which is inextricably woven with ritual. On the other hand, Rappaport defines ritual as "the performance of more or less invariant sequences of formal acts and utterances not entirely encoded by the performers."[29] Implied in this notion is a sense that the meaning attached to various rituals is not inherently obvious to those exposed to them. A certain encoding is required for a participant in a ritual to gain insights into the meaning attached to it. I argue that, rather than there being singular interpretations of meaning with respect to Christian symbols and ritual, there exist multiple interpretations of meaning.

In other words, the very nature of symbolism and ritual can lend itself to multiple

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[28] Roy Rappaport, *Ritual and Religion in the Making of Humanity* (Cambridge, U. K.: Cambridge University Press, 1999), 8.

[29] Ibid., 24.

interpretations in much the same way that a passage of scripture to a 13-year-old can have a different set of meanings when this 13-year-old is 85. While some interpretations of Christian symbols and rituals are indisputably foundational to the faith, I argue that there is room for variations in interpretations of meaning with respect to the use of Christian symbols and rituals. I believe that this is the case not only for clear-minded Christians, but also and especially for those living with end-stage dementia. With some prompting, one dementia patient might interpret a Nativity scene as being associated with Christmas, whereas another might respond to the same or similar symbol with a personal account of a favorite toy received during one Christmas during the Great Depression. We can infer from Rappaport's work that how chaplains understand the nature and quality of Christian symbols and ritual behavior is necessary to informing their best practices of using them and learning from them in caring for dementia patients.

Roy Oswald contributes to our focus on chaplains' best practices and deep understandings of them with dementia patients by arguing that for rituals to maintain their transcendent power, they should ". . . fit our theology and belief system, [and be able] to support and affirm what we believe about God, ourselves in relationship to God, and what we believe God desires for us."[30] He further argues that not all rituals are good ones. While some rituals lend themselves to positive transformation, others conversely lend themselves to sowing seeds of destruction and decay. He states that a prime example of bad rituals are those associated with the evil intentions of the Third Reich in Nazi Germany during World War II. Specifically, he lists "the swastika symbols . . . the goose-step marching, and requirement that Jews wear a star of David and have numbers tattooed

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[30] Roy Oswald, *Transforming Rituals: Daily Practices for Changing Lives* (Bethesda, MD: Alban Institute, 1999), 99.

on their arms in the death camps . . ."[31]

I tend to agree with Oswald that in order for rituals to have transformative power, they need to fit our theologies and belief systems. However, what happens when people forget their personal theologies and belief systems, as often applies in the case of dementia patients? In my working with dementia patients and chaplains serving them, I have found that when patients respond to rituals of sharing Christian symbols with them, they are more likely than not to be able to tap into their long-term religious memories. They might have forgotten some of the details of these memories, but they at least know that there is a God whom they have known and presumably still know.

Christian Symbolism and a Practical Theology of Dementia Care

It has already been established that inherent in the notion of Christian symbolism is a notion of action or movement. We sometimes refer to this action or movement as ritual. There are two dimensions to Christian symbolism. One involves rituals or moving acts and one involves sacred art. Both, however, can be viewed as discrete symbols in and of themselves. This dissertation acknowledges the symbolic power of sacred art. In the context of this dissertation, sacred art or Christian depictions are referred to as "Christian symbols." In this study, as chaplains show Christian symbols to Christian dementia patients (hereafter, simply "dementia patients"), the very act of their showing these symbols to their patients is a Christian symbol itself. This is so because ritual is a type of Christian symbol. Therefore, the chaplains are ritually or symbolically using Christian symbols in caring for their dementia patients. As alluded to earlier, the specific intention of the chaplains' dementia care interventions is to ritually help their patients

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[31] Ibid., 100.

experience transcendence. The chaplains' interventions can thus be viewed as their doing theology, and doing theology is at the core of the practice of practical theology. To help paint pictures of both chaplains' best practices in using Christian symbols with dementia patients and their discoveries associated with them, I will delve briefly into the relationship between doing theology and cognition.

William Van Roo states that "theology in itself is a cognitive activity."[32] On the one hand, I agree that it often is such. However, what about the case of dementia patients? I believe that everyone clear-minded or not does theology. For example, when dementia patients connect a crucifixion symbol with Jesus, they are doing theology, whether they are cognitively aware of it or not. I contend that they are able to do this, not so much on a cognitive basis, but on a spiritual one. The symbol taps into and awakens a spiritual memory or awareness that is independent of their cognitive ones. I assert that, at the same time chaplains are doing theology with their dementia patients, how they do it determines the degree to which their patients are also able to do theology. Therefore, it is through the lens of practical theology that I consider and critique the claims of both Van Roo and the scholars that follow in this dissertation.

Van Roo presents the sacraments of the Church as being complex symbolic acts. Since these symbolic acts have movement, they are by definition "rituals." Van Roo defines the Christian sacrament as follows: ". . . [it] is a complex symbolic action in which and by which the saving God shows forth what he is offering to, and realizing in, this man or woman."[33] In building a practical theology of dementia care, it is important to

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[32] William Van Roo, *Man the Symbolizer* (Rome: Gregorian University Press, 1981), 240.

[33] Ibid., 261.

note that, first and foremost, end-stage dementia patients often relate to the sacraments more affectively than cognitively. How they felt about their baptism and the communal intimacy of it is more important than their cognitive understanding of the sacrament. In viewing a baptismal symbol, one patient recalled fond memories of being baptized with her brother and mother many years ago. The chaplain's use of a tangible Christian symbol of a symbolic ritual or baptismal sacrament in this case invited the patient to temporarily transcend the limits of her illness. I believe that a side benefit also occurred, from the standpoint that the chaplain admitted to me during an interview that he himself felt as if he had been invited to enter the patient's transcendent world. Therefore, not only did the chaplain's use of a Christian symbol ritually help the patient transcend, it did the same for the chaplain. Thus, how chaplains use Christian symbols with their dementia patients can have communal benefits.

There are also benefits to chaplains using specific visual symbols depicting symbolic rituals, such as the sacraments. As Van Roo suggests, ". . . the sacraments are highly complex intuitive symbols."[34] For this reason, I believe that chaplains using Christian symbols with their dementia patients make the symbolic power of the sacraments more accessible. When they are made more accessible, they empower dementia patients to reach deep into their spiritual memories, thereby increasing their capacities to transcend.

In building chaplains' best practices of using Christian symbols with dementia patients and their learnings from these practices, it is important to take certain sensitivities into account. Andreas Andrepoulos states that Christ is "the most complete

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[34] Ibid., 262.

[Christian] symbol."[35] He further implies that there are some Christian symbols or depictions that are inherently misleading. He uses as an example God being depicted as a white-haired man and how that ". . . give[s] us the wrong idea about God and how we may relate to him."[36] I agree with Andrepoulos' position. The implication here is that perhaps the Bible's reference to God as a Father may be strictly symbolic. What is more important is that Jesus is the Son of God. Whether he is the Son to a male or a female is irrelevant and a distraction. Jesus' divinity transcends gender.

Just as male-gendered portrayals of God can be misleading, depictions of Jesus' skin color and nationality can also be distracting. That said, for far too long, symbols and depictions of Jesus portray him as being an attractive European. Such a depiction is not only misleading but historically inaccurate as well. Returning to my earlier point, should it really matter what color or nationality Jesus is? Because, at the end of the day, black or white, Jesus is who he claimed he is, which is the Son of God.

The real danger in depicting Jesus as blond-haired and blue-eyed is that it has the potential to play into a Eurocentric power dynamic that ultimately says that God is an old white man. Such a symbolic depiction of God has the power to alienate and exclude the already oppressed and marginalized children of God. What about dementia patients? They do not all reside in fancy, expensive, suburban assisted living facilities. Many of them reside in poor urban communities, whether in nursing homes or private dwellings. What do such symbols say to them? How do such symbols help them transcend? To the contrary, I believe they help them descend into abysses of despair. Chaplains would be

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[35] Andreas Andreopoulos, *The Sign of the Cross: The Gesture, The Mystery, The History* (Brewster, MA: Paraclete Press, 2006), 47.

[36] Ibid., 49.

well advised to, as much as possible, use somewhat generic depictions of Christ as they develop their best practices of using Christian symbols with dementia patients. Being historically accurate might appeal to some dementia patients. However, it could alienate others as well.

Not only images of God and Jesus have the potential to invite or exclude some dementia patients with regard to God's love. I assert that, over time, other images, such as the gender and ethnicities of ministers baptizing Christians, will increasingly affect how invited or excluded dementia patients feel. The same could be said for images of weddings and funerals. Moving forward, chaplains' attention to such potential sensitivities among dementia patients, whether realized or not, could be significant.

Given the commonality of baptism throughout Christendom, we will now focus on the symbolic power of this sacrament in terms of chaplains' best practices using Christian symbols and their subsequent discoveries. Some of the Christian symbols used in my research depicted baptisms. Again, I raise the notion of double symbolization. Double symbolization is when it is assumed that a chaplain's showing a symbol to a patient is a symbolic ritual in and of itself. The other meaning of *symbol* in such an intervention is what the symbol depicts, which in this case is the symbolic ritual of baptism. Put another way, in this context, such symbolization can be construed as using a symbol within a symbol. I believe that such symbolization increases the power of the intervention to aid in patient transcendence.

F. W. Dillistone discusses the symbolism associated with water beginning with antiquity. For example, he claims that it has been thought that heavenly water has life-giving characteristics. As a result, sprinkling water on a person connotes a renewal of life.

He further paints a picture of water that gushes from the earth. Since this water was associated with the womb, being submerged in it fostered immortality. In addition, he states that still water, also associated with the womb, symbolizes a return to the source of all creativity, which likewise suggests life renewal.[37] Dillistone asserts that water baptism symbolizes ". . . the seal of grace already given and waiting to be received," and that such a baptism has a cleansing connotation.[38] Specifically, this cleansing is from sin and causes the death of all earthly cravings through Christ's shed blood. This cleansing, in turn, is commonly thought to be a symbol of humankind's participation in Christ's death.[39]

There is a distinction between being sprinkled and being submerged into water in symbolizing a divine entry into eternal life. It is interesting to note, however, that the sufficiency of both of these acts in symbolizing this entrance has not been fully reconciled even to this day. Sprinkling, in some Christian denominations such as Catholicism, is sufficient for acknowledging that an initiate has been properly baptized. On the other hand, Baptists challenge the validity of administering this sacrament in such a way. For them, the only valid baptism is performed through immersion. Dillistone's take on the sacrament of baptism is that baptismal reforms need to focus on the communal symbolism of baptism and less on an individualistic one. Dillistone asserts this is the only way ". . . to fulfill [baptism's] proper function within the design and purpose of God."[40]

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[37] F. W. Dillistone, *Christianity and Symbolism* (Philadelphia: Westminster Press, 1955), 186.

[38] Ibid., 203.

[39] Ibid., 204.

[40] Ibid., 219.

As a Christian and ordained minister, I partially agree with his assertion. However, what happens in the case of individuals seeking baptism who have been cut off from a worshipping community, such as could be the case with some dementia patients? To tell them that they have been baptized into a community of faith is one thing, if they even know what baptism means. In cases when they understand its meaning, getting them to live this out is another issue. This is especially of concern when they do not have the presence of a substantial community to reinforce the communal meaning of their baptisms. In such cases, are isolated dementia believers' baptisms any less valid than if they worshipped within a community? I dare say they are not. Thus, contrary to Dillistone's position, I contend that there are some instances where it may be less important to try to focus believers' attention on the communal symbolism of this sacred rite as opposed to focusing on the washing away of their sin.

Concerning the distinction between sprinkling and immersion, what would happen if a housebound dementia patient was seeking a Baptist baptism? Using a bathtub may appear to solve this problem. However, many bathtubs are not large enough to allow for full immersion. This raises a significant question. Would such a patient be forced to seek another denomination in which to be baptized? There does not appear to be an easy answer to this question. However, it is worth noting that it could pose a theological dilemma.

Dillistone states that there are symbolic persons in addition to symbols associated with sacraments such as baptism. Among the most commonly viewed symbolic persons of the Christian tradition are Jesus and ministers. With respect to Jesus as a symbol, Dillistone appears to contradict himself. On the one hand, he claims that among humans,

Jesus was more of a prophet-reformer type of symbol than he was a priest-king one.[41] On the other hand, he later states that the priest-ruler continues to be the primary symbolic figure in the Church.[42] I argue that it would be hard to dispute that Jesus is the central symbolic figure in the Church. Since Dillistone clearly stated earlier that Jesus was not a priest-king symbol, there appears to be a contradiction. Perhaps Dillistone is still referring to Jesus as the primary symbolic figure in the Church. However, he may be referring to Jesus as a priest-king symbolic figure with creation being the reference point as opposed to humankind. If this is the case, he should have stated this point directly as opposed to leaving it to speculation. Concerning the sprinkling-immersion debate and the question of who is the central symbolic figure in the Church, there are practical theological implications. Chaplains using baptismal symbols with Catholic patients and patients whose baptism practices allow for sprinkling should consider using baptismal symbols depicting the use of sprinkling. Conversely, chaplains using baptism symbols with Baptists and others whose denominations encourage immersion should consider using baptismal symbols depicting full immersions.

Concerning Jesus as being the central symbolic figure in the Church as opposed to priests or ministers, the following would be helpful for chaplains to heed. I argue that, for some Catholics, Jesus and the Pope could possibly compete for receiving central symbolic figure status. I further assert that Protestant denominations would be more inclined to project Jesus as the central symbolic figure as opposed to high-ranking clergy. Chaplains spiritually caring for dementia patients with symbols should be sensitive to using ones in accordance with these differences. Doing otherwise could pose confusion.

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[41] Ibid., 130.
[42] Ibid., 133.

Ultimately, failing to take these differences into account could decrease a symbol's effectiveness in ritually helping a patient transcend.

Embedded in the preceding discussion of baptismal rituals and symbolic persons in Christianity is the notion of inclusiveness. As previously discussed, for a Christian symbol to be effective in promoting a sense of transcendence, it must have an inclusive reach. This claim is no less valid for dementia patients, especially since many places in the world are increasingly becoming multicultural. Chaplains spiritually caring for dementia patients are increasingly ministering to a heterogeneous population. In many segments of the world, people are being diagnosed with dementia. While many of them are Christians, the cultural contexts of their Christian witnesses vary. For example, in various urban centers in America, a typical nursing home could consist of Christian residents from a variety of cultures. How chaplains use symbols and what symbols they use can determine the degree of effectiveness they have in using them. They must keep in mind that to provide spiritual care in such contexts they must be diligent in using symbols that are inclusive of the various cultures of residents living within the facilities assigned to them. The same is true for chaplains serving Christian dementia patients in a variety of situations, including patients who reside in private homes. I agree with Daniel Fleming, who suggests, "Western Christian symbols, though older, are just as national as are Asian or African forms, and should not naively be assumed to be ordained for universal use."[43]

In order to determine the shape of chaplain's best practices of using Christian symbols with dementia patients and arrive at deep understandings of doing such, it is important for chaplains to understand how this disease affects dementia patients'

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[43] Daniel Fleming, *Christian Symbols in a World Community* (New York: Friendship Press, 1940), 29.

personhood. Dementia patients' sense of personhood is consistently and progressively under attack. Their ability to engage in meaningful or appropriate conversation is increasingly threatened as their disease progresses. Their loss of being able to meaningfully communicate creates a sense of suffering resulting from feeling disconnected, disintegrated, and not at home.[44] Scholars have attempted to symbolically increase dementia patients' personhood and thereby their spirituality. The interventions that Marty Richards and Sam Seicol suggest include sacraments, symbols, and familiar rituals.[45] Jean Clayton recommends the use of metaphorically-laden parables and psalms.[46] I believe that, however well intended Clayton is, this scholar's approach is flawed, because it has been my experience and that of my clinical colleagues that end-stage dementia patients have limited abilities to verbally connect in an extended manner. To Clayton's credit, I affirm that such dementia patients may be able to recall and recite familiar prayers such as the Lord's Prayer. However, their cognitive limitations preclude them from being able to verbally articulate any meaningful connections with passages of scripture, unless they are presented as phrases of a few words.

Even though end-stage dementia patients' ability to read words increasingly diminishes, I assert that in some cases their acts of reading from sacred texts can be seen as their engaging in rituals. I claim that this is a powerful symbolic tool similar to when

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[44] Astrid Norberg, "Communication in the Care of People with Severe Dementia," in *Aging, Communication, and Health: Linking Research and Practice for Successful Aging*, ed. Mary Lee Hummert and Jon F. Nussbaum (Mahwah, NJ: Lawrence Erlbaum, 2001), 159-160.

[45] Marty Richards and Sam Seicol, "The Challenge of Maintaining Spiritual Connectedness with Persons Institutionalized with Dementia," *Journal of Religious Gerontology* 7, no. 3 (1991): 35.

[46] Jean Clayton, "Let There be Life: An Approach to Worship with Alzheimer's Patients and Their Families," *The Journal of Pastoral Care* 45, no. 2 (1991): 177-178.

dementia patients participate in the ritual of having Christian symbols shown to them. Dementia patients are not the only ones to benefit from the use of Christian symbols. Participating in communion or connecting with communion via Christian symbols can be construed as ". . . deeply profound ways whereby caregivers can ensure that persons with dementia continue to feel accompanied on their journey through life, while refreshing their own spirit."[47] I believe that such a phenomenon speaks to ritual benefits that are extended to chaplains who use Christian symbols in caring for their dementia patients. I will discuss this in more detail later in this chapter.

Chaplains working with dementia patients must consider the notion of meaningful communication. Hospice chaplains are continually challenged as they seek to engage their dementia patients in meaningful communication. From whose point of view is meaningful conversation determined? What might be meaningful to the chaplain might not be meaningful to the patient. For this reason, it is imperative that chaplains at least temporarily suspend their notions of what is meaningful communication in order to reach the spiritual memories of their patients. Chaplains must be willing to try to make sense of the often terse responses they receive from their patients. As previously alluded to, a fundamental way chaplains can do this lies in their willingness to and skill in developing the personhoods of their patients. Chaplains' understandings of the social and relational challenges facing dementia patients are key to their ability to establish meaningful communication with them.

Perhaps some of the most meaningful communication chaplains can have with

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[47] Ellen Ryan, Lori Martin, and Amanda Beaman, "Communication Strategies to Promote Spiritual Well-Being among People with Dementia," *The Journal of Pastoral Care and Counseling* 59, no. 1-2 (2005): 55.

dementia patients is found through patients' abilities to reflect theologically despite, and in the face of, their cognitive declines. It should be noted that theological reflection in this context works both ways. I argue that, as chaplains are able to engage their patients in theological reflection, they too will be engaged in theological reflection. This is important because I believe that patient-chaplain theological reflection is foundational to developing a practical theology of dementia care. I will briefly discuss more about how chaplains theologically reflect in caring for their dementia patients after examining the notion of personhood in more depth.

First, let us consider some issues surrounding the notion of dementia patients doing theology. Peter Kevern presents three strategies for supporting dementia patients' personhoods found in early-intervention programs. Even though his strategies are aimed at patients in the early stages of dementia, I believe that they can be applied to those in late stages. I argue that this is so because, on any given day, late-stage dementia patients will exhibit moments of clarity often associated with earlier stages of dementia or with non-dementia individuals. To the extent that this is the case, late-stage dementia patients are capable of engaging in theological reflection.

What follows is a brief summary of these strategies and Kevern's critiques of them. The first strategy was developed by Kath Morgan. Her strategy assumes that the relationship between individuals and God is constant.[48] However, Kevern observes that this strategy is limited because it does not address what happens when patients no longer

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[48] Kath Morgan, "Meeting with God," personal communication with author, 2010, cited in Peter Kevern, "'I Pray that I Will Not Fall Over the Edge': What is Left of Faith after Dementia?" *Practical Theology* 4, no. 3 (2011): 285-287.

sense God's presence.[49] I, on the other hand, argue that, while no longer being able to fully articulate the constancy of their relationships with God, dementia patients often can acknowledge that God loves them. I have found this to be the case in my own clinical work. I visit many Christian dementia patients who present as generally disengaged from my attempts to communicate with them. However, often when I ask them, "Do you know that God loves you?" they respond with a simple "yes" or head nod. One could argue that they are simply saying "yes" to every closed-ended question I ask them. However, there are often times when they say, "no" or shake their heads when I ask them other questions that may be non-religious in nature. Despite being in late stages of dementia, these patients remain committed to their faith, and in so responding, they are acknowledging the very presence of God.

The second strategy Kevern presents stems from the theological reflection of Robert Davis, a former pastor who had Alzheimer's. Inherent in this strategy is an assumption that the dementia patient will struggle and decline until death occurs. Kevern argues that such a strategy lacks the potential to provide support and comfort because it does not expect anything other than death. With struggle and decline assumed to exist until death, Kevern points out that ". . . there is little room for a catastrophic challenge to expectations."[50] However, I side with Rev. Davis' suggestion of a firm hope existing within his approaching struggles and declines:

> Perhaps the journey that takes me away from reality into the blackness of that place of the blank, emotionless, unmoving, Alzheimer's stare is in reality a journey into the richest depths of God's love . . . . At that time, I will be unable to give you a clue, but perhaps we can talk about it later in the timeless joy of

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[49] Peter Kevern, "'I Pray that I Will Not Fall Over the Edge': What is Left of Faith after Dementia?" *Practical Theology* 4, no. 3 (2011): 291.

[50] Ibid.

heaven.[51]

When I reflect on the calm and peaceful demeanor of my pleasantly confused late-stage dementia patients as they acknowledge God's loving presence, I cannot help but recognize the comforting power of building a practical strategy that incorporates such a solid hope.

The last strategy Kevern presents is from the work of Christine Bryden, a dementia advocate who was diagnosed with dementia when she was only 46.[52] In her work, she raises the importance of living in the present moment:

> Dementia is often thought of as death by small steps, but we must ask ourselves what is really dying. Hasn't the person with dementia reached that place of 'now', of existing actively in the present? I believe that people with dementia are making an important journey from cognition, through emotion, into spirit.[53]

Kevern claims that such a strategy of being focused on the present has the advantage of helping dementia patients come to terms with the loss of their personal histories. However, he claims that such a strategy is not as comforting as it could be because it ignores the importance of religious rituals to the patients. I agree with both Bryden and Kevern on this point. I have found both personally and professionally that, in many respects, dementia patients primarily live in the present moment. However, I believe that the quality of their present-moment living is enhanced by their ability to tap into their ritual pasts. Sharing the symbols of pleasant former Christmas and Easter gatherings can become powerful rituals that shape the quality of dementia patients' present-oriented

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[51] Robert Davis and Betty Davis, *My Journey into Alzheimer's Disease* (Carol Stream, IL: Tyndale House, 1989), 120.

[52] Christine Bryden's website, Home page, http://www.christinebryden.com (accessed March 15, 2015).

[53] Christine Bryden, *Dancing with Dementia: My Story of Living Positively with Dementia* (London: Jessica Kingsley, 2005), 159.

living. I believe that focusing on the present at the expense of patients' celebrating their ritual pasts pays marginal returns. I also agree with Kevern's critique in this regard, because it is my assertion in this dissertation that dementia patients' sense and embracing of ritual is at the heart of their being able to transcend. I further claim that a practical theology of dementia care needs to incorporate dementia patients' ritual lives if it is going to be rich enough to promote spiritual transcendence. One powerful source for dementia patients' ritual lives is their reminiscences of childhood holidays.[54] I have found this to be the case when I have shown Christian symbols to some of my dementia patients. On a number of occasions, the symbols awakened fond memories of Christmas and Easter gatherings.

The following considerations are made with respect to dementia patients' theological reflections and their personhoods. With regard to the personhoods of dementia patients, I believe that acknowledging that they do theologically reflect, even in late stages, is key to strengthening their personhoods. Doing so has the effect of removing them from isolation and locating them in the social and relational worlds of their faith traditions. In this dissertation, my focus is on dementia patients from the Christian faith tradition.

Eric Stoddart suggests that chaplains working with dementia patients may want to do so in private settings, such as patients' rooms in care facilities, as opposed to in more public settings, such as day rooms.[55] While this may be true in theory, in practice it is often too difficult to implement. Due to the high caseloads many chaplains carry, the only

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[54] Eric Stoddart, "Dementia Care: Supporting a Plea for Personhood," *Scottish Journal of Healthcare Chaplaincy* 1 (1998): 11.

[55] Ibid.

time they can meet with some of their dementia patients is during mealtimes. Therefore, chaplains have to try to make the most of such situations. For example, I have found that using Christian symbols with dementia patients works best at mealtimes during the brief times when patients are sitting at their tables waiting to be served. It has been very challenging, if not rude, to try to show them symbols after their food has already been served.

Just as both patients and chaplains theologically reflect during visits, patients and chaplains' personhoods run the risk of increasing or decreasing during such occasions. Stoddart suggests that

> the very personhood of the carer is determined by his or her response to the person with dementia. A failure to take time to listen, an over eagerness to correct mistakes, to remove roles, and treat the person as irresponsible diminishes the carer's personhood as much as it does the person with dementia.[56]

I must admit that there have been several times when I have been in such a rush to cover my caseload that I have not been patient enough to carefully listen to my dementia patients respond to my showing them some Christian symbols. Sometimes I may have assumed that they were confused when, perhaps amidst their confusion, there was still some engagement. In these cases, had I used a little more prompting with hesitant or reluctant patients, they may have been better able to communicate their engagement with the symbols. I have found that harnessing patients' visits with my own clinical agendas can not only diminish my own sense of personhood, but be unethical as well. I am thus in total agreement with Stoddart's notion of the mutuality of increased or decreased personhood between patients and clinicians.

Practical theologian John Swinton focuses much of his work on dementia on the

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[56] Ibid.

notion of personhood. He raises the question of what actually constitutes personhood. In many ways, he flips the script on our preconceived notions of this dreaded disease. Swinton lays his foundation for developing a practical theology of dementia on several assumptions concerning what it means to be a person. Contrary to popular opinion, Swinton views dementia as being a communal problem. He further argues that it is not circumscribed by a loss of mind but by the perception of others that dementia sufferers have lost their minds. He claims that this perception is projected back onto individuals with dementia and used as a way of assessing their being and behavior. For him, dementia is not to be characterized by a loss of self, and any notions of a loss of self are to be attributed to a communal failing. In addition, symptoms such as aggression, depression, withdrawal, anxiety, and declines in emotional control, social behavior, or motivation can be explained in more than neurological terms. Swinton contends that such behaviors can be considered "normal" in light of challenging, scary, and frustrating circumstances. When caregivers do not take these matters into consideration, they can create negative interpretations that result from poor communication.[57] In keeping with Swinton's communal implications of dementia, I believe that community responses that fail to celebrate the personhood of dementia patients not only fail dementia patients, but substantially contribute to communities failing themselves by preventing them from communally reflecting and growing into the Imago Dei.

Philosopher Hilde Lindemann examines personhood from the perspective of second nature. For her, *second nature* is defined as habits of thought and action which

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[57] John Swinton, *Dementia: Living in the Memories of God* (Grand Rapids, MI: William B. Eerdmans Publishing, 2012), 108-109.

result from society's influence on our ability to "do morality" or be moral selves.[58] She views personhood as consisting of an attitude or stance toward individual persons. It is manifest by the degree to which society "holds" a person or recognizes the inherent worth of the person and acts accordingly.[59] Hilde maintains that there is a view that states expressing personhood and recognizing it in others is second nature. Stemming from this stance is a logic that asserts that the cognitive declines of dementia patients must necessarily cause them to lose their second natures and thus their abilities to participate in the practices of personhood. As such, they would be relegated to the status of being "nonpersons." She brings her point home by refuting such a stance on the grounds that ". . . after second nature has departed, the same force that imbued us with it in the first place can keep our personhood intact."[60] There is a suggestion here that this force is the very core of dementia patients' being and is characterized by their individual, unique selves.

Like Lindemann, I agree that the unique individual self of dementia patients is at the center of their abilities to thrive in spite of their illness. However, I believe that the self that is responsible for their thriving is more than a psychological or metaphysical sense of self, which I presume Lindemann is referring to, given her location as a philosopher. I contend that the sense of self that second nature gains its strength from is from a divine or transcendent self. Such a self is not bound by cognitive declines but, if stimulated sufficiently, is free to soar on the wings of the Holy Spirit.

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[58] Hilde Lindemann, "Second Nature and the Tragedy of Alzheimer's," in *Beyond Loss: Dementia, Identity, Personhood*, edited by Lars-Christer Hyden, Hilde Lindemann, and Jens Brockmeier (Oxford: Oxford University Press, 2014), 13.

[59] Ibid., 16-17.

[60] Ibid., 12.

In developing a practical theology of dementia care, it must be understood that theological reflection in this context is a two-way street. As alluded to earlier, as chaplains show Christian symbols to dementia patients, not only are the patients, in some cases, doing theology, but the chaplains are doing their own theological reflecting. It was established earlier that, in some ways, chaplains' showing dementia patients Christian symbols can be viewed as their engaging in rituals. As the chaplains use this intervention, both the patients and the chaplains have the potential to benefit from it. As the intended foci of the ritual, dementia patients have an increased possibility of being able to transcend the limits of their illness. However, I believe that such transcendence is not limited to patients. I contend that chaplains engaging in such rituals can be drawn into the transcendent worlds of their patients, even if only momentarily. They too can experience living in Bryden's transcendent "now."

In formulating best practices and deep understandings of using Christian symbols with dementia patients, chaplains are well advised to consider how Christian symbolism relates to God's providence. Thomas St. James O'Connor suggests that traditional Christian symbols have the power to awaken deep-seated feelings of trust in the providence of God that transcends the illness of dementia patients.[61] I agree with his assertion because trusting in God's providence forms a foundational spiritual platform from which dementia patients are able to leap beyond the cognitive limits of their illness. I further contend that such an abiding trust, often fashioned over a lifetime, is what ultimately allows them to transcend the limits of their illness. I believe that Christian

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[61] Thomas St. James O'Connor, "Ministry Without a Future: A Pastoral Care Approach to Patients With Senile Dementia," *The Journal of Pastoral Care* 46, no. 2 (1992): 10.

symbols accomplish this because they have the power to reactivate dementia patients' trust in the providence of God.

Toward the end of O'Connor's article, he shares that he was unsure of what traditional Christian symbols did for his patients. I find it odd that he could not know what the symbols did for them, especially since he raises the issue of how important nonverbal communication is in pastorally caring for dementia patients. It seems to me that, with his experience, he would be aware of the fact that it is not uncommon for dementia patients not to be able to verbally articulate how the symbols affected them and that it must be inferred from their affects and body language. All in all, I stand in agreement with O'Connor that trusting in God's providence is at the core of dementia patients' transcendence.

In keeping with my position that Christian symbols have the power to help dementia patients transcend, chaplains' practices can be enhanced by their understanding the relationship between Christian symbols and transcendence. Such an understanding can help them gain deeper understandings of the symbols' true power. Rollo May addresses the transcendent power of symbols. While he refers to symbols in general, I believe that his ideas can apply to Christian symbols as well. For May, the transcendent power of symbols is based on the fact that they ". . . *discover for us a reality outside* . . . They are roads to universals beyond discrete concrete experience."[62] May makes this assertion with no mention of there being any special cases in which it applies or does not apply. Therefore, we are to assume that, from his perspective, his assertion is generally true. That said, I contend that, in the case of dementia patients, it is false.

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[62] Rollo May, "The Significance of Symbols," in *Symbolism in Religion and Literature*, ed. Rollo May (New York: George Braziller, 1960), 46.

His notion of universals implies that there are universal realities. I claim that universal realities do not exist for dementia patients. Their realities are instead relative and unique ones. Even symbols such as Jesus on the cross do not necessarily evoke an awareness of God's redemptive love for us as might be expected to be universally true among Christians without dementia. Oftentimes, instead, the symbol of the crucifix might evoke feelings of an unexplainable sadness or anger with some dementia patients. Chaplains using Christian symbols are well advised to take the non-universality of Christian symbols into account, if for no other reason than to avoid any frustration on their part when their patients do not respond in generally expected ways.

The process of determining best practices of using Christian symbols with dementia patients can be illuminated by chaplains understanding the relationship between transcendence and memory. Urban Holmes' sense of the transcendent power of Christian symbols is rooted in memory. For him, Christian symbols' power derives "from the connection made between the memory of the individual participants and the representation of the Passion through means of ritual symbols."[63] I challenge him on this point on two fronts. First, I have asserted throughout this paper that dementia patients' transcendence stems from an awakened spiritual memory, since their cognitive declines increasingly preclude them from having significant recall surrounding what the particular symbol represents. In some respects, I believe that as dementia patients' cognitive memories fade, their spiritual memories increase. I further assert that the transcendent power of Christian symbols is rooted in more than the Passion narrative. I claim this to be true because I have witnessed dementia patients connecting with symbols other than

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[63] Urban Holmes, *Spirituality for Ministry* (San Francisco: Harper & Row, 1982), 136.

those related to Christ's Passion. Symbols surrounding the birth of Christ also have a powerful ability to ritually help dementia patients transcend. It seems that this is true to the extent that the Nativity symbols awaken spiritual memories of the intimacy often associated with family Christmas gatherings.

Thus far in this dissertation, I have provided an introduction to my research as well as a literature review on the Christian story, rituals, and Christian symbols as they relate to chaplains working with dementia patients. In Chapter 3, I will engage in Osmer's descriptive-empirical task by describing my research methods and presenting my research findings.

CHAPTER 3

The Descriptive Task: Research Methods and Findings

This chapter covers the descriptive-empirical aspect of my research. I began with two research questions: What are best practices for hospice chaplains using Christian symbols with dementia patients? What do hospice chaplains learn from using Christian symbols with dementia patients? The first question seeks to gain an understanding of what hospice chaplains' best practices of using Christian symbols with dementia patients look like. The second question is designed to uncover what hospice chaplains learn from using these symbols in providing dementia care. The chapter then describes the research participants, the methods used, and the interviews, followed by a summary of the themes that emerged from the data. The chapter concludes with a discussion of the study's findings and their unique contributions to both the academic and clinical fields.

Research Participants and Methods

The chaplains described in Chapter 1 – Chaplain Frazier, Chaplain Garrison, and Chaplain Nathan[1] – visited six patients and showed Christian symbols to each of them. Each chaplain was assigned two patients. They were asked to visit each of their two patients three times over the course of nine months, from March to December 2014. There were five female patients and one male patient, ranging in age from 88 to 97. What follows is a breakdown of the patient participants by name, age, and diagnosis (the ages given are the ages they were during the study).

Terry[2] – female, 92, Vascular Dementia

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[1] These are pseudonyms. They are used throughout this dissertation in order to protect the identities of the chaplains.

[2] All of these patient names are also pseudonyms designed to protect the patients' identities. They are used throughout this study.

Gill – male, 90, Vascular Dementia
Lilly – female, 97, Vascular Dementia
Bonnie – female, 96, Congestive Heart Failure (she presented dementia symptoms)
Tina – female, 88, Alzheimer's Disease
Nan – female, 95, Alzheimer's Disease

Ethical safeguards were taken to protect the participants. An IRB Research Plan, including an informed consent form and privacy protection guidelines for both chaplain and patient participants, was submitted to the chair of the Claremont School of Theology IRB in February 2014. It was approved later that month. All of the research data (clinical note summaries and interviews) has been de-identified by using pseudonyms. Concerning the first round of interviews that were conducted between the spring of 2014 and the following fall, one of them was conducted at 1424 Canfield Avenue in Dayton, Ohio. The remaining two were conducted in the chapel of Hospice of Dayton. The second round of interviews was conducted in December 2014. One was conducted at a local restaurant during off hours; one was conducted by phone; and one was conducted in the chapel of Hospice of Dayton. Both rounds of interviews were recorded using a password-protected digital voice recorder. Each of the interviews was transcribed using a professional online transcribing service. The clinical notes, accompanying summaries, interviews, and interview transcripts are all housed on a password-protected laptop computer. All of the research data will be deleted within four months of this dissertation's defense. The interview questions are included in this chapter.

The chaplains were each asked to show Christian symbols representing the following five categories to their assigned patients: Jesus' nativity, crucifixion, and resurrection and the sacraments of baptism and the Lord's Supper. These categories were selected based on their each being common within the Christian faith. The chaplains were

instructed to show individual symbols or a combination of them to their dementia patients in order to attempt to engage them in meaningful communication. The chaplains were told to follow their patients' lead with regard to deciding how long each visit should last. They were further instructed that if any of their patients desired not to be shown Christian symbols to refrain from showing them. Similarly, if any of their patients, after having already begun viewing symbols, desired to refrain from continuing to view them, they were free to do so without penalty, as outlined in the informed consent form. The chaplains were also free to withdraw from the study at any point without penalty, again per the informed consent guidelines. The chaplains were asked to document their use of Christian symbols in their clinical notes. For the purposes of privacy protection, the chaplains were required to convert their clinical note references concerning Christian symbols into de-identified clinical note summaries that used the patients' pseudonyms.

Thematic analysis was performed using the clinical note summaries (see Appendix A for samples). Each of these summaries was coded in order to capture and explore emergent themes. The following clinical note summary codes were used:

- SR – Symbol Recognition
- NSR – No Symbol Recognition
- SPH – Symbol Prompting Helpful
- SPU – Symbol Prompting Unhelpful
- PUOS – Patient Unable/Unwilling to Observe Symbol

"SR" indicates the patient recognized the symbol. Accordingly, "NSR" means the patient did not recognize the symbol. "SPH" indicates that the chaplain's use of prompting to gain a patient's response to a symbol was helpful, and "SPU" means that the chaplain's use of symbol prompting was unhelpful. Symbol prompting is defined as the act of chaplains making revealing statements designed to stimulate and encourage patient

engagement with the symbols. In some cases, the chaplains would actually tell patients what they were viewing. This would sometimes lead to patients sharing their sacred stories, thus revealing their symbol engagement. These stories were sometimes associated with past holiday gatherings as well as participation in the sacraments. However, sometimes revealing prompts would be ineffective or unhelpful. Changing them or creating new prompts would occasionally remedy these situations. "PUOS" is used to indicate that the patient was unable or unwilling to observe the symbol.

The clinical note summary codes, then, served the purpose of capturing both the effects and strategies the chaplains employed in using symbols. The first round of interview questions were derived from the clinical note summary codes. While the patients' responses to the symbols were recorded, they were done so only to place the chaplains' use of them in context. The thinking here is that patient responses to the symbols or the symbols' effects is significant to the extent that the way chaplains showed symbols was often determined by initial patient responses to them. In other words, when patients did not recognize a symbol, chaplains had some strategic decisions to make.

First, the chaplains needed to decide if symbol prompting might facilitate patients' symbol recognition. Second, if chaplains' use of prompting did not lead patients to recognize symbols or make meaningful connections, the chaplains were then faced with decisions of whether or not to continue using the intervention. These strategies formed the basis of this study's attempts to determine the chaplains' best practices and their understandings of them.

Chapter Four will present an interpretation of the data in light of my literature review and findings. Accordingly, in addition to examining best practices, it will cover

more fully what it means to chaplains to use Christian symbols in terms of their understandings of their roles as spiritual caregivers, effects on them personally, and the values they attach to this intervention. It will also provide insights into their understandings of dementia patients and their relationships with them, the presence or action of God, the human spirit, and Biblical or theological themes when using Christian symbols with dementia patients. The first round of interview questions primarily focused on symbols' effects and chaplains' strategies in using Christian symbols. The chaplains' strategies were explored during both rounds of interviews, whereas the symbols' effects were considered primarily in the first round.

For Chaplain Frazier, during the six visits he made, his two patients eventually recognized some of the symbols that were shown to them. He also found symbol prompting to be helpful [3] At times his patients were either unable or unwilling to observe the symbols shown to them. Likewise, Chaplain Garrison's patients sometimes recognized the symbols that were shown to them.. She reported that symbol prompting was generally helpful during her six visits As with Frazier, at times her patients were either unable or unwilling to observe the symbols. Chaplain Nathan's patients similarly recognized some of the symbols shown to them. She also found symbol prompting to be helpful She rarely experienced times when her patients were unable or unwilling to view the symbols.

Trustworthiness of the Study

The trustworthiness of this study is expressed in terms of research triangulation and researcher bias. Through the use of clinical note summaries, interviews, and

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[3] "Helpful" symbol prompting is prompting that stimulates communication from the patient.

interview follow-up questions and answers, the study's themes are more contextually and plausibly understood. In conducting this study, any researcher bias stems from the researcher's past experiences and location.

My mother lived with dementia until her death 23 years ago. Therefore, I have collected, analyzed, and interpreted this data through this personal experiential lens. I am socially located as a middle-aged African-American from the inner city of New York, where I attended public schools before relocating to the Philadelphia area for both my bachelor's and first master's degree. I came of age during the 1970s, which was during much of America's civil rights movement and the end of the country's involvement in the Vietnam conflict. I grew up among key intimates who were substantially older than I, and my parents were both over 40 years my senior. Professionally, I am a second-career ordained minister who has served as a hospice chaplain for nearly a decade in the Los Angeles and Dayton, Ohio regions.

Analyses of the First Interviews

This section provides analyses of the first interviews based on the interview transcripts (a sample of Chaplain Frazier's first interview transcript is provided in Appendix B). The interview questions that were used in the first round of interviews were aimed at providing an understanding of both the effects of using Christian symbols and the strategies employed in their use. Some were also aimed at understanding the motivations the chaplains had in using symbols with their patients. The following are the interview questions that were asked during the first round of interviews (they were not necessarily asked in this order).

1. How did you feel when your patients did not recognize the symbols? Why?
2. How did you feel when your patients recognized the symbols? Why?

3. Could showing symbols and prompting be seen as a ritual? If so, how?
4. Was there a connection between your patients' need for structure and ritual with showing symbols? Explain.
5. Was there a connection between your showing symbols and possible ritual needs for you? Explain.
6. Did you use symbol prompting? If so, why?
7. Do you attach familial or communal significance to your showing symbols? Explain.
8. How did the patient's wanting you to leave make you feel?
9. Were there reasons you used the Crucifix symbol as opposed to the Cross? Explain.
10. Are patients' symbols more powerful than chaplains' symbols? If so, why?
11. Are one-word patient responses sufficient indicators of meaningful patient communication? If so, why?
12. What did your enjoyment of using Christian symbols look like?

Chaplain Frazier's First Interview

Throughout the interview, Frazier shared how he strategically used Christian symbols to help his patients ultimately transcend. Early in the interview, he explained a decision he made about what type of symbol not to show his patient, Terry: "Knowing her religious background, I didn't present anything . . . that might have made her assume that this was [a] Catholic [symbol]." Thus, he made a strategic assumption concerning her possible denominational biases. For example, he chose to use communion symbols that depicted small cups as opposed to chalices. He did not want the patient to become ". . . distracted by something that she may react to in Catholicism." For similar reasons, Frazier chose to use baptismal symbols depicting immersions as opposed to sprinklings, which is often how Catholic baptisms occur. He raised the issue of the often-debated validity of sprinkling versus immersion, but he clearly pointed out that he is not biased toward either form of baptizing.

Chaplain Frazier grew into having an appreciation for symbol prompting. He admitted that at first he was reluctant to prompt his patients to stimulate their engagement

with symbols. However, he eventually came to the place of believing "it's necessary." As the coding revealed, Frazier found symbol prompting to be helpful on more occasions than not. He offers an example of when symbol prompting was unhelpful in working with Gill. Specifically, Frazier showed Gill a picture of a priest serving communion. The priest was holding the host above his eye level. Frazier referred to the priest's garb in an attempt to promote symbol recognition with Gill. However, Frazier's prompting did not lead to Gill's recognition of the communion symbol.

Frazier is open to embracing the notion that the act of showing his patients Christian symbols can be seen as a ritual in and of itself. He believes that using Christian symbols with his patients can possibly help them remember something meaningful to them. He claimed that some dementia patients' need for ritual was connected with their need for structure, as opposed to functioning haphazardly. For himself, he was reluctant to acknowledge any unmet needs for ritual. He stated that he is not a ritualistic minister and sees a downside to over-ritualizing because it results in the loss of a ritual's meaning and power.

One very practical strategic consideration Frazier raised is the need for the symbol to be bright enough to be seen by the patient. In working with Gill, there were instances where Frazier chose not to use certain symbols because they were too dark. He shared that the visibility of a symbol's image is an example of how he became intentional about which symbols to use with Gill and which ones not to use.

Frazier was intentional about using a suite of symbol interventions when he deemed it was warranted. When he showed Gill a baptismal symbol, he next showed him a crucifix. He pointed out that he shifted his symbol focus with Gill: "I started out with a

wide scope, and then described more details as time went on." In using the baptismal symbol with Gill, Frazier recalled that including the word *baptism* in the symbol stimulated the patient to recall that he had, in fact, been baptized. This episode supports the thinking that reading is an ability dementia patients tend to retain well into their disease progressions.

The following examples reveal some of Chaplain Frazier's motivations in using the symbols he chose. At one point in working with Terry, she voiced her displeasure at being shown a Christmas scene. Frazier shared with me his frustration over the patient's displeasure. However, despite the patient's displeasure and his frustration, Frazier was motivated to give it one more try: "I thought that if I could calmly remind her or spark something in her mind that would be meaningful to her, that I would go further." Since Frazier had been successful in engaging the patient with a baptismal symbol during an earlier visit, he wanted to recreate that outcome. However, when Terry continued to express displeasure when Frazier attempted to show her the Christmas scene again, Frazier's frustration led him to cease showing symbols to her. Despite this negative outcome in light of the patient's prior engagement, trying to show her a symbol once more was a risk he was willing to take. On one occasion while working with Gill, Frazier intentionally affirmed the patient in his ability to recall some of his religious history. Frazier shared his motivation for affirming the patient in recalling his Catholicism: "I just wanted to give him . . . affirmation, to build on that meaning to him, to communicate to him his recollections were . . . meaningful, spiritual, that there was something to it. I wanted him to hear and receive that his religious experience was good for him."

One of Frazier's biggest motivations for using Christian symbols was evident

when he first used a baptism symbol with Terry. Terry was intentional about sharing that, during her baptism, she was in the water with her brother and mother. The patient's response indicates and displays the level of her engagement with the symbol, and this had a motivational effect on Frazier. Frazier detailed both the patient's transcendence and his own, observing that Terry's story about her brother became meaningful to him:

> I kind of almost had a religious experience listening to her describe it, the meaning in her voice and the way she changed and her recollection . . . The next time I go see her, she won't remember that I've ever been there before, but her brother, in the water with her, that was meaningful to her . . . It was like she took me there in describing it . . . It was like all my frustrations early in this process and all my attempts to get [her] to recognize religious symbols . . . was all worthwhile.

Frazier continued,

> . . . in just this five-minute experience with this woman, who was taken back to that family time, that shared experience, that touch of God in her life, that I felt a touch of God myself . . . that five-minute block of time convinced me that I need to keep this image.

As he used Christian symbols with dementia patients, Frazier felt on a number of occasions various emotions stirred up within him. He stated that he felt relieved when Terry recognized symbols shown to her because he did not believe previously that she would be able to do so. When she did not recognize symbols, he became "mad at her." However, after several attempts with both Terry and Gill, he was able to get over his frustrations with their lack of symbol recognition.

Frazier recounted another set of feelings he had when showing symbols to Gill. He pointed out that he had been visiting Gill for over a year. During most of this time, Frazier was not aware that Gill had been raised Catholic. It was not until he began showing Christian symbols to Gill that Frazier discovered that Gill had a Catholic background. When I asked him how he felt about his late discovery of Gill's earlier

Catholic experiences, he stated that it made him feel "like I hadn't been paying attention to him, like I'd missed something with him . . . that I had let him down as a chaplain, that I hadn't listened close enough or probed it deeply enough into where his spirituality came from."

Chaplain Frazier's First Interview Follow-Up Questions and Answers

Question 1: Overall, to what extent do you believe that the type of Christian symbols you used helped your patients relate to God?

Response 1:

> The reactions the images received were sporadic. It took some effort to get the patients to see and/or recognize them and when they did, the helpfulness therein appeared to be somewhat limited. Each patient had an area that struck him/her in particular, and memories came that encouraged them and/or had meaning.

Question 2: Were there Christian symbol types that helped your patients relate to God more than others? Which ones were they?

Response 2: "The symbols that seemed most useful were Christmas and baptism."

Question 3: Why do you believe some Christian symbol types helped your patients, overall, relate to God more than other Christian symbol types?

Response 3:

> Images of resurrection were mainly unidentifiable in the minds of the patients; it must have appeared to them to be merely art of a person standing beside a cliff (outside the tomb). Not even the angels or the women in the garden or a halo in the image referred the patients to the resurrection. Communion did not appear to connect either – a priest presenting the elements, the use of the word[s] *host*, *bread*, *wine*, *loaf*, *wafer*, *wheat*, *grapes*, *chalice*, *cups* did not help to any great extent.

Chaplain Garrison's First Interview

Chaplain Garrison provided insights from a broad perspective. Her primary strategy in showing Christian symbols to dementia patients was to think in terms of how

the symbols could help patients relate to God as opposed to help them focus on God. At first glance, it might appear to be a small point. However, for Garrison it was not: "I think *relate* is a better term, because if you show the crucifix, then people relate that to church or prayer or quietness or reverence." Like Chaplains Frazier and Nathan, Garrison noted that sometimes using a combination of symbols was effective in connecting with patients. She also observed instances when symbols influenced her patients' affects.

Garrison reported that the most effective symbol she used was the cross. It was the most relatable symbol for those patients who responded. Conversely, she found the Nativity symbols the least effective for connecting her patients with God because the symbols confused them. She recounted some frustration in using Nativity symbols. Garrison's motivation for using Christian symbols with dementia patients was rooted in her desire to help them relate to God more.

Given that Garrison's interview responses were in broad terms, the following analysis of her clinical note summaries is in order. I will raise what I believe are pertinent and reflective questions and share some reflections of my own. The notes for Garrison's first visit with Lilly state, "Chaplain pointed to images of Christmas in patient's room." Christmas was over at that point, so how can the fact that Christmas images were still being displayed be interpreted? Garrison suggested that this could be interpreted in several ways. It could be that Lilly's family had not yet taken them down or that Christmas was meaningful and perhaps one of her favorite holidays. This raises a question of intervention efficacy. Would it be more effective for stimulating patient communication for chaplains to use symbols that personally belong to patients, rather than those from their own symbol toolkits? In such a case, as was pointed out by

Chaplain Frazier, symbols should be visible to the patient. As long as the patient's personal symbol is logistically accessible to her during the visit, it should have just as much power to stimulate meaningful patient communication as when using chaplains' symbols. Further research is needed to determine how the efficacy of using patients' personal Christian symbols compares with chaplains using their own.

During Garrison's second visit with Lilly, the patient responded to a symbol of the crucifixion by saying, "Jesus." It appeared that the patient was stimulated enough by the symbol to provide a one-word response. However, I raise the question of whether or not one-word responses sufficiently demonstrate meaningful communication. In this case, I believe that the power behind the name "Jesus" speaks volumes. Similarly, during the first visit, Lilly replied, "This is good," following Garrison's informing her that a volunteer was coming to serve her communion. Again, these are only a few words, but many hospice dementia patients can only speak in sentences of a few words. The context in which Lilly said, "This is good," gives her reply that much more meaning. When Garrison affirmed Lilly's correctly identifying Jesus in the crucifixion symbol, one can only wonder how this affirmation might have affected Lilly's faith.

Chaplain Garrison's First Interview Follow-Up Questions and Answers

Question 1: Overall, to what extent do you believe that the type of Christian symbols you used helped your patients relate to God?

Response 1:

> For the patients that were surveyed, I think it helped some to associate a symbol with what I was asking of them. I tried to say the words, and at times it confused them, and other visits, they were clearer. This is because of cognition decline or where their mental status was for that day of processing. It was at least a useful tool that most could identify with.

Question 2: Overall, were there Christian symbol types that helped your patients relate to God more than others? Which ones were they?

Response 2: "Crucifixion was the most popular because it is one that just about everyone has seen at some point in their lives."

Question 3: Why do you believe some Christian symbol types helped your patients, overall, relate to God more than other Christian symbol types?

Response 3:

> The crucifixion sign, I believe, helped for prayer because they could somewhat figure out what I was asking of them to do or it was what I was going to do. The Nativity scene symbol can confuse because it looks like a house or barn, and so I think it may have been thought of as a farm and people in front. Too much for the patient to process.

Chaplain Nathan's First Interview

I am going to analyze Chaplain Nathan's work with patients Tina and Nan through the following three lenses. First, I will analyze the strategies she employed in how she used symbols with them. Second, I will offer some insights into Nathan's motivations for using the symbols she did. Finally, I will uncover various feelings she had in showing Christian symbols to her patients. Since some of her responses can be viewed through several lenses, I do not necessarily move through them sequentially.

Chaplain Nathan found that showing Christian symbols to Tina generally gave her visits with her more structure and meaning. The symbols' effectiveness in creating more visit structure was best captured by Nathan when she declared, "We weren't doing anything until I started with the pictures and then she became part of it." As far as meaning is concerned, Nathan stated that this intervention ". . . gave us an avenue of discussion, conversation. If one picture didn't bring out anything interesting that she

wanted to say, another picture did." Nathan further reported that the intervention ". . . made me feel like we accomplished something . . ." and ". . . that made me feel good." Thus, Nathan's success with showing symbols to Tina can be viewed as an underlying motivation for her to continue using them to stimulate both meaningful conversation and transcendence.

While one of this study's foci is on the chaplains' feelings about using the interventions, it is worth noting that Tina enjoyed participating in this intervention as well, which was evidenced by Nathan's claim that "she didn't want me to stop," and Tina's asking, "Are you gonna come back?" It appears that Nathan's use of the symbols with Tina had a reciprocally beneficial effect. When the symbols stimulated Tina, that created positive feelings within the chaplain. In turn, I believe that some of the chaplain's positive feelings not only motivated her to continue using this intervention, but it helped motivate Tina to meaningfully engage with them as well.

Not all of the symbols shown to Tina generated positive engagement, and sometimes what did not work in one visit did in another. When Nathan showed Tina a symbol of Christ's empty tomb for a second time, unlike her positive response to it during an earlier visit, this time, according to Nathan, that was not the case. Nathan stated, "This time she looked at it differently, and she was like, 'Well, who would be in there? Why would someone be in that dark place?'" It should also be noted that when a particular symbol, such as that of Christ's empty tomb, initially generated a negative response, through the aid of prompting Tina was able to positively engage with the symbol. According to Nathan, "When I mentioned that it was Easter, she said, 'Oh,' and then I sang. I started singing, 'Up from the Grave He Arose,' and she sang with me, and

then it went from a negative to a positive, just within a phrase of a song and the picture together."

I stated earlier that Tina did not always respond to the same symbol the same way all of the time. On Nathan's third visit with Tina, her positive response to the baptismal symbol was in stark contrast to an earlier one. Nathan shared that Tina's earlier description of the symbol as being "cute" changed. Apparently, Tina now viewed the symbol through a wider lens or context. Earlier, she had focused on the cuteness of the baby. However, on this third visit, Tina noted that water was being poured on the baby's head. Nathan's assessment that this response was negative was evidenced by her saying something akin to, "Why in the world would someone pour water on his head?" Nevertheless, even though Tina did not like water being poured on the baby's head, "She knew this was done at church. And then when we talked about it, then it went back to that she knew . . . what it was."

Tina's focus on food and family can be captured by her response to a Nativity or Christmas symbol. In recounting a former Christmas gathering, Tina shared that her mother was sitting at a table, and she wanted Nathan to know about dinner. This led to Nathan and Tina's discussion about the ritual of Christmas. Nathan shared that the symbol was so powerful that, along with prompting, Tina was led to point to a chair across from where the two of them were sitting at a large conference table and say, "Well, my mother's right there." Nathan continued to share that Tina ". . . began to tell me about this beautiful Christmas table . . . And she would tell me all the things that they would do and make."

Nathan noted that different symbols of communion stimulated different responses

from Tina. A symbol with a communion tray initially did not have the same impact on Tina as did one depicting a loaf of bread and juice in a cup. Nathan interpreted Tina's recognition of the latter as being due to her being " . . . so tuned into food, family, relationships." Nathan suggested that Tina's notion of family reflected a "family of faith, community . . . Groups of people that you're with become family because . . . even in her residential facility, she would find a family atmosphere with some of those patients and the workers." Nathan observed that when a symbol, such as the symbol of the tray of cups and wafers, did not initially stimulate recognition, prompting would lead Tina to respond, like she did when she acknowledged she had had communion using a loaf of bread and wine. Nathan claimed that this recognition was largely due to the presence of two symbols within the same category, which jointly stimulated easier symbol recognition, meaningful communication, and transcendence.

Patient Nan tended to have more curt responses than Tina did. On the surface, she appeared not to be as engaged with the symbols as Tina was. However, when she was engaged, the intensity of her responses was significant. Upon viewing a symbol of the crucifixion, Nan frowned and became saddened, as evidenced by her making remarks such as, "Why would someone do this?" and, "It was too bad that this man was dying." Nathan observed, "Then as quickly as that comment changed, she said, 'That's enough,' and she wanted to stop." Chaplain Nathan shared that Nan's abruptly cutting off the conversation stirred up feelings of disappointment. However, Nan's welcoming future visits from Nathan helped the chaplain get over her frustration.

Nathan believed there might be some ritual implications with respect to Nan's willingness to participate in being shown Christian symbols. Even if Nan did not

recognize or connect with some of the symbols, Nathan maintained that "she liked participating." As far as the ritual of showing Christian symbols to Nan was concerned, Nathan shared that her ritual need of sharing her faith was met.

Nathan's interview transcript points to some practical considerations for chaplains to be attuned to when showing Christian symbols to dementia patients. One of them is the timing of the visit. It would be less distracting if chaplains' visits could be done in the morning, sometime between breakfast and lunch time. Also, by doing the visits early in the day, the patients are less likely to be too tired to participate. Along these lines, the evening could pose distractions due to the fact that some patients might experience sundowning. Room temperature can likewise become a distraction if it is either too cold or too hot in the visit locations. On one visit, Nan became distracted because the room was too cold. Nathan shared that she experienced frustration because of this. Nathan suggested that learning about a patient's background and interests can also aid in stimulating meaningful communication and transcendence. Implied in Nathan's use of the symbol of communion with Nan is a need for flexibility in using various symbols. As was the case with Tina, two different symbols depicting communion can stimulate recognition. Both the communion symbols of trays and those of bread and wine were recognized by Nan at different times.

Chaplain Nathan also observed that showing the exact same symbol to a patient on different occasions can generate varying responses. According to Nathan, it was not until her third visit with Nan that the quality of her response to the crucifixion symbol changed. On both her first and second visits with Nan, even with prompting, Nan viewed the crucifixion symbol as being negative. However, on the third visit, Nan picked out a

positive feature of the symbol. It was the image of the sun. It was not until this third visit that Nan was able to bring a positive connotation to the symbol that previously had only represented death. Nathan believed, however, that even though Nan found something positive in the crucifixion symbol the third time, it is unlikely that it stimulated any connotations of the grace of God's redemptive love that are embedded in the crucifixion symbol.

Nathan's motivations for using and continuing to use Christian symbols with dementia patients are attributed to a number of factors. Overall, Nathan stated that using the symbols ". . . was edifying to me, to see that I had something there that [Tina] could relate to, that she took an interest in, and it was even better when she continued with it, when she kept talking and it led to other things." Perhaps one of Nathan's strongest motivations for using Christian symbols with Tina is captured by the following:

> Well, by the time we were finished, especially once we got into the Nativity, the Christmas traditions, and baking cookies . . . one of the workers came over, and [Tina] explained about oatmeal cookies and all this to the girl that came over. [Tina] enjoyed herself. She was happy, laughing . . . cheerful . . . Her whole mood was different, where she was just reserved at the beginning, not knowing what we were gonna be doing. And she just had a full time. And I did, too. . . . I could have sat there for a lot longer. I didn't want to tire her, but we just shared memories and experiences, and it was just a good time. . . . I felt close to her. . . . I knew something about her now that was real. . . . And she didn't want it to end. And she said, "Please come bring more pictures." She wanted more pictures, more pictures, so I thought that was super.

Chaplain Nathan's First Interview Follow-Up Questions and Answers

Question 1: Overall, to what extent do you believe that the type of Christian symbols you used helped your patients relate to God?

Response 1: "The Christian symbols stimulated conversation. Patients shared stories of Christian traditions, church services, and personal joys."

Question 2: Were there Christian symbol types that helped your patients relate to God more than others? Which ones were they?

Response 2: "Yes. The Nativity and the tomb [resurrection] both awakened memories of times celebrating Christmas and Easter."

Question 3: Why do you believe some Christian symbol types helped your patients, overall, relate to God more than other Christian symbol types?

Response 3: "I believe some Christian symbols helped patients to connect with the past. It was interesting to watch the patients work through the cues and process the gained information to suddenly remember family gatherings and festivities."

Analyses of the Second Interviews

The second round of interviews was conducted in December 2014. This round focused exclusively on exploring the chaplains' best practices of using Christian symbols with dementia patients and their understandings surrounding these best practices. The questions that were asked were designed to uncover themes regarding the chaplains' best practices and their subsequent discoveries. A sample of Chaplain Nathan's second interview transcript is provided in Appendix B.

1. The following are the questions that were asked during the second round of interviews:What would you do differently when using Christian symbols with dementia patients?
2. What would you suggest to new or other chaplains when using these symbols?
3. What impact does your experience using Christian symbols with dementia patients have on your view of being a spiritual caregiver?
4. How has your experience using these symbols affected you personally in caring for dementia patients?
5. In terms of both strengths and growing edges, what did you learn about yourself in your experience of using Christian symbols with dementia patients?
6. On a scale of 1-5, how would you rate the value of your experience, where 1 is having the least value and 5 is having the most value? Why?

7. What did you learn about dementia patients as a result of using these symbols?
8. In what ways did you experience God's presence or action while using these symbols?
9. How did your relationship with dementia patients shift when you used these symbols?
10. What did you learn about the human spirit when using these symbols with dementia patients?
11. What Biblical or theological themes come to mind when you reflect on your experience using these symbols with dementia patients?

Below is a list and descriptions of the 11 themes that emerged from analyzing the second interview transcripts. Two themes stated later in the dissertation emerged from the first interviews, bringing the total number of dissertation themes to 13.

1. Expectations – the expectations that each chaplain assigned to using the intervention
2. Patience – the need chaplains felt for being patient in using the intervention
3. Flexibility – the need chaplains found for being flexible in using the intervention
4. Being in the Moment – the need chaplains assigned to being in the present moment while using the intervention and the discovery of its importance
5. Confidence-Builder – the quality of building chaplains' confidence in using the intervention and the subsequent discoveries of confidence chaplains made
6. Frustration – chaplains' discoveries of being frustrated in using the intervention
7. Non-clinical Benefits – chaplains' discoveries of how using the intervention helped them in their personal lives
8. Intimacy – the chaplains' discoveries of the relationship between using the intervention and intimacy with dementia patients
9. Personhood – the chaplains' discoveries of holistically viewing dementia patients
10. Faith Identification – chaplains' discoveries of the role using the intervention played in their faith formation
11. Sacred Stories – chaplains' discoveries of how using the intervention led to the telling of sacred stories

In the following subsections I will analyze each chaplain's second interview transcript as it relates to the above themes.

Chaplain Frazier

According to Chaplain Frazier, chaplains need to be flexible when using Christian symbols with dementia patients. He believes that one such way of being flexible is to prompt or guide patients in both understanding the symbols and being able to verbally and or nonverbally articulate this understanding. He stated that there is a connection between chaplains' frustration and their expectations in using the symbols. Essentially, he felt that the lower the expectations chaplains have in using this intervention, the less frustrated they are likely to become. Frazier captured his frustration when he said, "Even more than how the patients reacted is my reaction to them. When they didn't get it . . . I was beside myself with frustration that they didn't get it." Frazier admitted that the degree of his frustration was less when he worked with patients who ". . . were lower on the [expectation] scale."

Chaplain Frazier believes that it is important for chaplains to be in the moment as they practice using Christian symbols. He stated, "Whatever [the patients] can latch onto, whatever it is at that moment, . . . run with it, . . . be where they are." He claimed that "during that moment I was with them in some spiritual way," and he indicated that this was an important discovery for him as well.

> If somebody wants to talk about a sports car and not about prayer, my role is supportive in wherever that person is . . . And if they want to talk about when they were 17 and they got picked up for drag racing, and that's where they are that moment, that's fine. And most people will laugh at that kind of thing . . . It doesn't mean it's not spiritual. It doesn't mean it's not important. Just to be where people are, wherever that is. And it may take four conversations before someone comes around to a religious realm. And there may be a dozen conversations and the religious realm doesn't come up because that's not where they are and that's not where they want to be, and that's okay.

According to Frazier, his experience using Christian symbols with dementia patients "crystallized for me that dementia patients are always in the moment."

Chaplain Frazier indicated that there are non-clinical benefits for chaplains who use Christian symbols with dementia patients. His appreciation for using symbols in this way demonstrates a broadening of his overall view of the value of Christian symbols. He shared this in the context of the sociocultural backdrop of his youth, when he believed that symbols were "silly," and in light of the fact that he "grew up in the '60s, where symbolism was looked down upon."

Frazier claimed that using Christian symbols in this way helped him in his faith formation:

> Just looking at these images and leafing through them with [dementia patients] has . . . allowed me to reflect on my experiences with God and God's people over the years. About my home church and about the people who supported me in that context, about me as a pastor having experienced a nine-year-old girl who, after taking communion, said, "Boy, Jesus' blood tasted good today."

This reflection also reemphasized the need for him to be patient in using Christian symbols with dementia patients. I imagine that this understanding would help lower his frustration in using this intervention or perhaps be a sign that his frustration had, in fact, been reduced through the use of it. Using symbols helped Frazier strengthen his relationships with his patients and his ability to connect with them on a more intimate level. As he put it, "Our relationship is different and stronger and more positive . . . because we shared a specific experience that otherwise would not have happened."

Chaplain Frazier has found that using Christian symbols with dementia patients has helped him celebrate their personhood:

> A person's history holds . . . meaning and maybe even a spirituality . . . that [a patient's] parents took him to church and led him on that

> journey . . . Even though he has trouble remembering those events, that in some ways deep within his soul, those events still affect him, make him the . . . person he is.

In reflecting on his experience with this intervention, Chaplain Frazier recalled people of the Bible and the sacredness of their stories. For example, he was reminded of ". . . when Jesus walked into the water with John the Baptist and when Paul talks about the meaning and the importance of the Eucharist and the gluttony of the Corinthians, who were practicing it incorrectly." He was also reminded of the personhood of God throughout the ages:

> . . . I think of the 12 stones that were . . . constructed . . . at the edge of the Jordan so that the people throughout history could remember that God ushered them into the Promised Land, and these 12 stones stacked up are symbols of what God did . . . hundreds of years ago. But there they are, testifying, symbolizing, helping us recall, helping us tell the stories of God's goodness and faithfulness. And then the . . . remembering of the Passover, the story told around the table as the meal is eaten, and the goodness and faithfulness and deliverance of God is recalled [and] passed on to generations.

Chaplain Garrison

With regard to flexibility, like Chaplain Frazier, Chaplain Garrison believes that chaplains should view their use of Christian symbols as part of their intervention toolkits. According to her, "If a person cannot communicate, then this is one way that they would be able to." She argued that it is important to stay open-minded to embracing new tools or "better ways to communicate spiritual things to people." Chaplain Garrison also recommended that chaplains be flexible about making intervention shifts based on where patients happen to be cognition-wise at any given moment. Garrison found that her open-mindedness and flexibility with using Christian symbols with dementia patients had non-clinical benefits as well. Many of the people she knows have parents who are

experiencing cognitive declines, so in communicating with them she uses "more gestures [and] symbols."

Garrison also stated the need for chaplains to set realistic expectations when using Christian symbols with dementia patients. According to her, this intervention is not useful for all dementia patients. For some, "it may [be] too late in the game for them" to benefit from it. Even though she claimed that this intervention is not appropriate for all dementia patients, she did take note of the fact that slight moments of progress eased some of her frustrations in using it and helped her, like Chaplain Frazier, appreciate this intervention's ability to celebrate the present moment.

Chaplain Garrison noted a connection between Christian symbols and sacred stories. She drew a parallel between Egyptian hieroglyphics' ability to convey stories and messages, many of which were sacred in nature. According to her, "Some of the [stories] that are locked in [dementia patients'] hearts and minds and spirits can be brought forth because they've seen [a Christian] symbol." Garrison believes that the Christian symbols she used in this study resonated with her patients because they are ultimately based on stories of hope and love.

Chaplain Nathan

Like Chaplains Frazier and Garrison, Chaplain Nathan believes that chaplains should be flexible in how they use Christian symbols with dementia patients. Moving forward, she shared that she would use different or non-religious symbols to help get patients relaxed before introducing the Christian ones. Nathan stated that she ". . . would add some very common pictures. Maybe [the] environment, outside pictures, [and]

animal pictures." She believed that in adding such pictures, "More conversation will occur."

Chaplain Nathan gave two examples of instances when using Christian symbols with dementia patients could or did promote confidence. In answering the question, "What would you suggest to new or other chaplains when using these symbols?" she suggested that using these symbols can give chaplains a solid foundation on which to foster and build communication. She shared how new chaplains often are at a loss for what to say or do in trying to communicate with dementia patients. Using Christian symbols with them is therefore a way of filling those often awkward moments at the beginning of a visit, and thus, it is a tool that should increase chaplains' confidence in caring for dementia patients. Nathan shared a significant discovery resulting from her use of Christian symbols: "It empowered me to have another way of communicating [with them]."

Like Chaplains Frazier and Garrison, Chaplain Nathan discovered non-clinical benefits of using Christian symbols with dementia patients. She recounted the use of these symbols with her mother-in-law, who lives with dementia. While Nathan was showing her symbols, she began "pulling memories out and sharing them." She asserted, "It's really helped in our family to communicate with her on a . . . higher level."

Similar to Frazier and Garrison, Nathan witnessed embracing the present moment as both a chaplaincy best practice and a discovery with respect to using Christian symbols with her patients. According to her, "I loved being with the [dementia patients]." Nathan also referred to a sense of being in the moment when she asserted, "God was in these moments with [my dementia patients] in the church."

Both Frazier and Garrison believe that it is important to set realistic expectations when using this intervention with dementia patients. They both claimed that this is a way for chaplains to pace themselves and reduce the amount of frustration they encounter. Nathan's sense of expectation with this intervention, on the other hand, was grounded in a looking forward to "visiting . . . people with dementia." She had this expectation because she believes these patients "have [a] treasure inside and it's kind of locked at the moment."

Like Chaplain Frazier, Chaplain Nathan reported that using Christian symbols with dementia patients fostered a strong sense of intimacy between her and her patients. According to Nathan, "After doing this, it became an ice breaker into a conversation. They would reach out their hand. They would touch me. I could touch their arm. We had a verbal exchange. There was interest on both of our parts." Like Chaplain Frazier, Chaplain Nathan observed a direct relationship between her using Christian symbols with dementia patients and her faith as it has been formed through Catholicism.

While Chaplain Frazier celebrates dementia patients' personal history, Chaplain Nathan celebrates the personhood of her patients through the lens of viewing them as total persons. She captured the essence of this point when she said, "I really believe that [dementia patients] aren't people that are just put in a place, left there until they die. [They] are people that have something to offer. They offer the past, their memories, [and] their experiences."

Chaplain Nathan also observed the interplay between chaplains' using Christian symbols and sacred stories. She suggested that the accuracy of stories' details is subordinate to their meaning. She recounted an experience where a dementia patient

confused baby Jesus in the manger with David. Nathan stated that this was all right because the patient's confusing David with Jesus led to their having a conversation about how strong and wise David was. What was more important than the patient's remembering specific story incidents was her ability and readiness to converse about a Bible character who had meaning to her. The sacred stories the symbols evoked were not just those of or related to the Bible but were sometimes from the lives of the patients. Nathan shared what such stories looked like, saying they were ". . . mostly about how [dementia patients] had to be strong and courageous [and that] making decisions . . . was hard for them sometimes. And so, when it was hard for them to get something out, we would talk about, 'Oh, Daniel was in the lion's den. He had to have courage.'"

Finally, Chaplain Nathan emphasized the importance of patience when using Christian symbols with dementia patients. Speaking to the role of chaplaincy, she asserted that in using this intervention, "We need to take our time, not be in a rush . . . It may take more than one minute. It may take five minutes. It may take a course of over a couple of days, a couple of visits. Be patient."

The analysis of the first round of interview transcripts and follow-up questions and answers was based on four themes. These themes were used to explore both the strategies or best practices and effects of chaplains' using Christian symbols with dementia patients. The second round of interviews were examined through the lenses of the 11 themes discussed earlier in order to delve further into what the best practices of the chaplains studied were. Of no less importance is an analysis of some of the salient discoveries the chaplains made when implementing these best practices. In the next section, I will present a summary of my research findings using both sets of themes.

Summary of Research Findings

In the 21st century, there are many pressures and issues facing hospice chaplains as they spiritually care for patients in general and end-stage dementia patients in particular. From my location and that of the three hospice chaplains in this study, we sometimes feel like we are on the frontline and rapidly running out of ammunition. With dementia diagnoses on the rise worldwide and with no visible cure in sight, it is no overstatement to say that modern healthcare is in a war against dementia and dementia-related illnesses. Hospice chaplains, in particular, are often called to manage high caseloads with an increasing percentage of dementia patients on them.

As practical theologians, we chaplains are called to enable "the faithful performance of the gospel . . . [while] exploring and taking seriously the complex dynamics of the human encounter with God."[4] The question and primary issue at stake in today's healthcare environment as far as dementia care is concerned is, "How do we use our pastoral identities to spiritually care for dementia patients responsibly and faithfully?" How we attempt to address this point speaks volumes to our collective dedication to being prophetic voices for dementia patients, who are often the marginalized of the marginalized.

One such way I have proposed for using our pastoral identities to establish and maintain our prophetic voices within the Christian community is to share a glimpse of the divine with dementia patients through the use of Christian symbols. There is a significant body of research concerning the use of music as a means to help caregivers of dementia patients meaningfully connect with them. However, there has yet to be studied how

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[4] Swinton, *Practical Theology and Qualitative Research*, 1.

spiritual caregivers, particularly hospice chaplains, can use the sense of sight, through the aid of Christian symbolism, to care for dementia patients. This research is important and necessary in order to advance the body of knowledge within both the clinical world and the academy in how to meaningfully care for end-stage dementia patients through accessible and practical methods.

As hospice chaplains or other chaplains caring for end-stage dementia patients share glimpses of the divine with them, their sacred duties as ordained spiritual caregivers are being challenged. Their sacred responsibilities mandate that they share part of themselves and their deep spiritual longings with the voiceless. At the root of chaplains' deep spiritual longings are their very pastoral identities, which are continually in processes of being defined and formed. In order to gain deeper understandings of how their pastoral identities are formed and transformed, it behooves them to gain some insights into what constitutes effective practices of using Christian symbols and what they can learn through the implementation of such practices.

Beyond merely identifying some of the effects of Christian symbols on dementia patients, the chaplains in this study were able to both identify standards of best practices in using this intervention as well as reflect on various discoveries associated with their use. Based on the personal testimonies in the chaplain interviews, I believe that many of their discoveries associated with their best practices actually facilitated the shaping of their pastoral identities. I further assert that much of their discoveries were fueled by their commitment to helping their patients both grow into the Imago Dei and experience a sense of Christian community.

The first round of interviews and follow-up conversations focused on some of the

effects of chaplains using Christian symbols with dementia patients. As already discussed, this was done in order to place the chaplains' behavior in context. The strategy of prompting the patients formed the basis of one of the best practices in using this intervention. The themes, therefore, for the first round of interviews were accordingly whether or not patients recognized the symbols and whether or not chaplains' symbol promptings with the patients were helpful or not. The second round of interviews explored additional best practices and the discoveries the chaplains made in using them.

The 11 themes previously mentioned emerged from these interviews. Some of them provide a deeper understanding of what faithful and responsible chaplain practices look like when helping dementia patients transcend or corporately grow into the Imago Dei. In addition, many of the themes provide insights into chaplains' understandings or discoveries that aided them in more faithfully and responsibly helping their patients corporately grow into the image of God. In many respects, the sense of community fostered by the chaplains using Christian symbols with their dementia patients was based on a community of two people, namely, the patient and the chaplain. Some of the themes are related to both chaplains' best practices and their discoveries.

Having engaged in the descriptive task of describing my study's research methods and summarizing its findings in this chapter, I will turn in Chapter Four to the interpretive task. In this chapter, I will interpret the data through the lenses of my literature review and research findings.

CHAPTER 4

The Interpretive Task

In this chapter, I will interpret the study's data through the aid of the literature. It must be noted, however, that given the fact that this study is breaking ground in understanding how Christian symbolism can aid chaplains in spiritually caring for dementia patients, much of what I will do is make connections and inferences from the literature to bring greater understanding to this study's research findings. First, I will explore the themes related to chaplains' best practices of using symbols with dementia patients. Then I will examine the themes associated with the chaplains' discoveries from using the symbols.

As a rule, when chaplains had realistic expectations about utilizing this intervention, its efficacy increased. Having realistic expectations meant not expecting patients to connect immediately with the symbols. Closely related to having realistic expectations is the theme of frustration. It was found in this study that there tended to be a close relationship between the degree of the chaplains' expectations and the degree to which they became frustrated when using this intervention. Generally speaking, the more the chaplains set realistic expectations, the less frustrated they became in working with the symbols. Conversely, the less the chaplains set realistic expectations, the more frustrated they became. Similarly, the more patient the chaplains were when using this intervention, the less frustrated they became, and the less patient they were, the more frustrated they were. Flexibility in using the symbols also helped decrease chaplains' frustration and ultimately helped increase the effectiveness of the intervention.

The more the chaplains embraced being in the moment, the more they were able

to connect with their patients. This was not only a standard best practice, it was also one of the discoveries the chaplains tended to make. While the chaplains had a general theoretical understanding of the need to be in the present moment with their patients, this concept was strengthened within them as they actually embraced and used it in practice. As the chaplains became more confident in using the symbols, they were able to more easily guide their patients toward transcendence. The theme of confidence-builder was therefore both a form of good practice and a discovery the chaplains tended to make in their practices.

The remainder of the themes are each related to the chaplains' discoveries or deep understandings gleaned and reflected through their use. Unbeknownst to the chaplains before their involvement in the study was the fact that there are non-clinical benefits associated with using this intervention. These benefits include the ability of the chaplains to better understand how Christian symbolism has helped them in their personal lives. They gained deeper understandings for communicating with either their friends or family members with dementia. In one case, using the intervention helped a chaplain better understand some of the challenges her friends experience in caring for family members with dementia.

For the most part, the chaplains in this study experienced greater intimacy in their relationships with their dementia patients by using Christian symbols. There appeared to be a relationship between the degree of this intimacy and the degree to which the chaplains embraced the personhood of their patients. In other words, the more the chaplain viewed and respected his or her patients as whole persons with rich stories and experiences from the past, the more the chaplain was able to celebrate his or her patients

in the here and now. The chaplains' abilities to holistically celebrate their patients played significant roles in guiding them toward transcendence. Their use of Christian symbols also facilitated the process of broadening their pastoral identities. This was accomplished as the chaplains were able to engage in faith identification and connect their use of the intervention with sacred stories. Some of the chaplains' understandings and commitments to their own faith were enhanced through their use of Christian symbols. Likewise, the more chaplains were able to draw parallels between sacred Bible stories and themes, the more they were able to reflectively appreciate the value of using this intervention with their dementia patients. Similarly, it tended to provide the chaplains with a deeper understanding of how some of their patients' stories connected with Biblical ones.

I will interpret the study's data through the following interpretive lenses, two of which are the same as Chapter Two's first two sections; the third interpretive lens is taken from part of Chapter Two's final section. The lenses are "the Christian story and dementia care," "ritual and dementia care," and "personhood and dementia care." Below I connect the dissertation's 13 themes (2 from the first set of interviews and 11 from the second set of interviews) with these interpretive lenses.

The Christian Story and Dementia Care

1. Faith Identification
2. Sacred Stories

Ritual and Dementia Care

3. Symbol Recognition
4. Symbol Prompting
5. Expectations
6. Frustration (also listed as a theme viewed through the *Personhood and Dementia* lens)
7. Patience
8. Flexibility
9. Being in the Moment
10. Confidence Builder

Personhood and Dementia Care

6. Frustration (also listed as a theme viewed through the *Ritual and Dementia* lens)
11. Intimacy
12. Personhood
13. Non-Clinical Benefits

The Christian Story and Dementia Care

As chaplains seek to faithfully and responsibly guide dementia patients toward transcendence through the aid of Christian symbols, they must first be able to understand the narrative contexts associated with both dementia patients and their stories and these contexts' significance. The patients' faith identifications shape each of their stories and help each to be more contextually understood. Both the Christian dementia patients and Christian chaplains share the same faith in terms of their mutual identification with key historical events and sacraments of the Church. These key events and sacraments are the incarnation, death, and resurrection of Jesus and the celebration of the sacraments of baptism and communion. The historical value of the birth, death, and resurrection of Jesus is subordinate to the symbolic meaning of these stories.

Like Niebuhr suggests, for the revealed meaning of the Christian story to spring forth, it must be viewed in terms of our collective histories or stories.[1] As chaplains are able to more fully identify with their faith, they are in stronger positions to help their dementia patients do the same. While dementia patients often struggle with identifying with their faith, chaplains, through the aid of Christian symbols, can help them more deeply connect with their faith. The chaplains in this study, through the aid of Christian symbols, allowed their individual faith stories to momentarily merge with their patients'. I believe that as each of their stories merged, they also united with the sacred story of the

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[1] Niehbuhr, "The Story of Our Life," 29-30.

Gospel and, in turn, collectively allowed both the patients and the chaplains to more fully reflect a communal growing into the Imago Dei.

The chaplains in this study generally were sensitive to the fact that underlying their perception of some of their patients' confusion in articulating their faith stories was the notion that dementia patients' stories often reflect non-universal realities more so than in the general population. Also, the chaplains in this study were usually aware that, in keeping with Navone's scholarship, much of their patients' theological confusion stemmed from the dynamic tension between their own latent faith stories and those found in the Gospels.[2] Finally, the chaplains in this study understood that their use of Christian symbols was based on Tilley's assumption that the Gospel is "an unsurpassable story . . . beyond human capacity to hear or tell," and as such has the potential to evoke various interpretations.[3] Before I delve into examining the chaplains' behaviors and subsequent discoveries, it should first be noted that the patients' stories, the chaplains' stories, and their merged version with the Gospel story can each be viewed as sacred actions or rituals in and of themselves.[4] I believe this is true because embedded in story are senses of movement and action that give stories their life. I submit that the telling of these stories only reinforces their ritual power.

Ritual and Dementia Care

This section will explore the relationship between ritual, dementia, and the themes of symbol recognition, symbol prompting, expectations, patience, flexibility, being in the moment, and confidence builder. One way the ritual aspect of the chaplains' using

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[2] Navone, *Seeking God in Story*, 42.
[3] Tilley, *Story Theology*, 212.
[4] Buber, *Werke III*, 71.

Christian symbols with their dementia patients was manifested in this study was through whether or not the symbols were recognized by their patients. Therefore, not only was their showing their patients the symbols a ritual but, I contend, the patients' positive verbal or nonverbal engagement with the symbols can equally be viewed as ritualistic behavior. This is so because religious ritual, by its very nature, is an action that reflects underlying sacred meanings, and positive patient responses to the chaplains' symbols was akin to their saying, "I may have forgotten a lot, but I have not forgotten that there is a God who loves me."

Amidst the chaplains' using Christian symbols is an interplay of ritual behavior stemming from both the chaplains and the patients. Both chaplains and patients in the study had a ". . . particular way of looking at and organizing the world."[5] The chaplains' choices of which Christian symbols to use with their dementia patients reflected their understandings of the symbolic ritual power of using them. In addition, the ritual power of their using Christian symbols can be viewed either indirectly or directly. Indirectly, the symbol is itself a ritual to the extent that embedded in it is the Christian story. The Christian story, in turn, is also an indirect ritual because it suggests movement through various plot sequences. I have referred to this way of viewing symbols within symbols as "double-symbolization." Similarly, rituals within rituals can thus be viewed as "double-ritualizing." In both cases, I believe that this doubling up effect of ritually working with Christian symbols strengthens the overall effect of the intervention in promoting both patients' and chaplains' transcendence. The direct ritual aspect associated with chaplains' using Christian symbols with dementia patients is the actual showing of them to their

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[5] Bell, *Ritual*, xi.

patients. Finally, the patients' positive verbal or nonverbal responses to the symbols can be viewed as being a direct ritual because they are actions that imply a deeper spiritual meaning than what might appear on the surface.

Associated with the ritual act of using the symbols is whether or not the chaplains in the study used prompting to help their patients transcend. Of particular importance is whether or not the chaplains' use of symbol prompting was helpful. As the chaplains in this study increasingly prompted their patients when using Christian symbols, their intervention gained more ritual power to guide their patients toward transcendence. This was due to the fact that prompting the patients encouraged them to momentarily step out of their mundane stories long enough to enter into sacred ones.

The chaplains in this study were not necessarily aware of the extent to which their behavior was ritualistic. However, when Frazier and Nathan reflected on their experiences in their first interviews, they were both able to acknowledge some parallels between their using Christian symbols and the idea of ritual. They based this assessment on their perception that their dementia patients tend to benefit from structure because it helps them in their overall functioning. While Frazier and Nathan acknowledged this ritual benefit for some of their patients, they also were open to the fact that they too benefited from the ritual aspects of using Christian symbols.

Both Frazier and Nathan experienced ritual's accountability to ". . . forces that transcend it . . ."[6] Frazier admitted that not only did he observe patient transcendence with respect to the ritual or sacrament of baptism, but he too transcended in proportion to the patient's transcendence. It is worth noting that both patient Terry and Chaplain

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[6] Ibid., 21.

Frazier experienced communal transcendence. Terry's transcendence was communal because it was done in the context of her being baptized with both her mother and brother. Likewise, Frazier's transcendence was communal from the standpoint that he transcended along with Terry, albeit in distinct ways.

Nathan, on the other hand, acknowledged her own transcendence as she experienced one of her patients do so. In this case, her patient experienced a communal transcendence when she linked the symbols of communion, Christmas, and Easter with warm and inviting memories of past family gatherings. The patient's transcendence radiated beyond memories of the patient's sacred gatherings and invited Chaplain Nathan to momentarily sup and dine within those memories. Like Terry, the transcendence of Chaplain Nathan's patient, Tina, was communal because it was connected to the company of intimate others, namely family members. Similarly, Nathan's transcendence was communal since it was closely linked to Tina's transcendence. In this regard, both of these chaplains and their patients communally grew into the Imago Dei.

Several factors were at work in informing the ritual power of the chaplains' using Christian symbols with their dementia patients. In addition to the themes of symbol recognition and symbol prompting in this study were themes consisting of chaplains' expectations in using Christian symbols with dementia patients, the degree of their frustration and patience in using them, how flexible they were in utilizing them, how much they embraced being in the moment in working with them, and how their practices were confidence builders for them.

It became apparent in analyzing the second set of interview transcripts that the chaplains' effectiveness in ritually promoting patient transcendence was linked to the

preceding themes. For the most part, the chaplains experienced some level of frustration in using the Christian symbols with their dementia patients. One of the main ways they were able to lower their frustration levels was to manage their expectations in using them by not expecting too much from the patients in terms of their connecting with the symbols. Related to having realistic expectations was being patient in using the symbols, especially given the major cognitive declines the patients possessed. Likewise, the more flexible the chaplains were in utilizing different types of Christian symbols, the more they were able to lower their frustration levels and build confidence in using them. If a Nativity symbol did not work on a particular visit, sometimes a baptism or communion one would. Another way the chaplains were able to build confidence in using the symbols was to be as fully as possible in the moment with their patients. In this way, they were able to increase the ability of their patients to transcend, by, as Kevern implies, honoring the importance of the faith rituals of their patients.[7]

It appears that at the root of the chaplains' frustrations in ritually caring for their patients is that, as Rappaport suggests, ". . . the meaning attached to various rituals is not inherently obvious to those exposed to it."[8] It is worth remembering that there are many expressions of Christianity as reflected in the many Protestant denominations that exist. Even within Catholicism, there are variations in the order of service and cultural influences affecting it. Within the study itself were patients who had once attended low church services and some who were familiar with more high church worship. Given the various congregational and worship locations of the patients within the study, it is no wonder that some patients engaged with some of the Christian symbols more than with

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[7] Kevern, "'I Pray that I Will Not Fall,'" 159.
[8] Rappaport, *Ritual and Religion*, 8.

others. The chaplains in the study tended to be sensitive to this issue, which I believe played a significant role in managing both their frustration and expectations.

Oswald reminds us that not all rituals are good ones.[9] For example, a baptism symbol shown to one patient in the study reminded her of happy times sharing a sacred moment with her family. On the other hand, another patient viewed another baptism symbol as negative because water was being poured on a baby's head. Thus, the same ritual, in this case baptism, evoked both positive and negative connotations within some of the study's participants. The degree to which the ritual elicited positive or negative responses also contributed to the degree to which the studied dementia patients were able to transcend and communally reflect the image of God.

Personhood and Dementia Care

The themes that will be focused on in this section are those of frustration, intimacy, personhood, and non-clinical benefits. The frustration of the chaplains in this study can also be viewed from the Kantian perspective expressed by Crites as follows: "Consciousness has a form of its own, without which no coherent experience at all would be possible."[10] I believe that as long as the chaplains focused on solely ministering to the conscious minds of their patients, they were essentially likely to continue to beat their heads against a wall. Thus, when the chaplains' initial frustrations began to mount, they were able to increase their effectiveness by abandoning their attempts to solely reach their patients' conscious minds, which were clearly compromised by their illnesses. It was not until these chaplains sought to ritually tap into their patients' still intact spiritual minds or memories that their frustration became more manageable.

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[9] Oswald, *Transforming Rituals*, 99.
[10] Crites, "The Narrative Quality of Experience," 72.

I believe another reason the studied chaplains became less frustrated was that they had an unconscious awareness that, just as clear-minded individuals do theology, so, too, do dementia patients, albeit in different ways. I am aware that my assertion flies in the face of some scholarship, particularly that of Van Roo, who claims that "theology in itself is a cognitive activity."[11] However, there were too many instances in the study where everyday conversations appeared to be more of a cognitive activity with some of the patients than were theological conversations. Some of the patients' abilities to tell stories sacred to them in response to being ritually shown Christian symbols bears witness to my assertion.

I further bolster my argument that dementia patients do theology by pointing out that some of the patients in this study were able to connect with symbols or rituals depicting the sacraments of baptism and the Eucharist. However, they tended to do so through the patient support of their chaplains' prompting them to engage with these symbolic ritual depictions. Therefore, I continue to argue that, even though, as Van Roo purports, ". . . the sacraments are highly complex intuitive symbols," their complexity is not so great that dementia patients cannot identify with them. Again, from the perspective of this study, some of the patients were more likely to resonate with symbols of the sacraments as their chaplains became less frustrated. Chaplain frustration thus worked in two directions. As the chaplains were able to use their symbols to connect with their patients, they became less frustrated, and their becoming less frustrated, in some measure, helped their patients connect and transcend with the symbols.

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[11] Van Roo, *Man the Symbolizer*, 240.

Perhaps in an even more significant way, chaplains were able to lower their levels of frustration in using Christian symbols as they began to identify and respect the personhood of their patients. Like some of Job's friends in the Hebrew Bible, the chaplains in this study became increasingly at ease with sitting with their dementia patients in their suffering. I believe these chaplains were able to identify with the suffering of their patients as they faced the fact that their patients in some ways have been physically, cognitively, emotionally, and spiritually dislocated from themselves. As Norberg implies, their suffering often results from feeling disconnected, disintegrated, and not at home.[12] Having empathized with their patients and acknowledged their marginalization, these chaplains were in strong positions to celebrate these persons as whole children of God with vibrant pasts and meaningful presents, despite the challenges their illnesses present them with. The chaplains, in effect, were able to meaningfully connect with their patients and guide them toward transcendence through, as Richards and Seicol recommend, sacraments, symbols, and familiar rituals.[13]

Not only was chaplain frustration lessened as the chaplains celebrated the personhood of their patients, but both patient and chaplain transcendence was encouraged. I assert that at the root of chaplain or patient transcendence is an ability for each to theologically reflect. As was discussed earlier, some of the patients in this study were able to do theology or theologically reflect through viewing Christian symbols. The evidence was often in their ability to relate the sacredness of the symbols to the sacredness of their own stories, some of which centered on memories of strong family

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[12] Norberg, "Communication in the Care of People," 159-160.

[13] Richards and Seicol, "The Challenge of Maintaining Spiritual Connectedness," 35.

relationships. I believe that these patients' ability to theologically reflect was at the root of their transcendence because, in many respects, their theologically reflecting was evidence of their transcending. I further contend that the patients' abilities to theologically reflect in turn encouraged the chaplains to do their own theological reflecting, as was made evident during my interviews with them. As the chaplains strengthened their theological stances, they in turn were able to continue to stimulate their patients to transcend even farther. An example of this is when Chaplain Frazier experienced his own transcendence while observing one of his patients transcend through the use of a baptismal symbol. This experience motivated him to continue to prompt the patient during her transcendence, drawing her even closer into communally reflecting the Imago Dei.

Equally as important as the chaplains' managing their frustration in using Christian symbols with dementia patients was this intervention's ability to foster a more intimate relationship between patients and chaplains. No longer was the patient simply another dementia patient that needed to be visited in order to meet Medicare requirements. Now, through the intimacy forged through this intervention, the whole person living with dementia began to gradually appear, take shape, and manifest in the chaplain's view. Now this often marginalized and slumped-over figure in a wheelchair was seen by the chaplain as a full-fledged human being and child of the most high and gracious God, whom we as hospice chaplains are sacredly charged to serve. As alluded to earlier, I claim that theological reflection, on the part of both the patients and chaplains, was the conduit for bolstering the intimate bond between these chaplains and the personhoods of the studied patients.

In the following discussion, I will explore the relationship between the studied patients' theologically reflecting, their transcendence, and their personhood as it relates to the chaplains' using Christian symbols with them. As some of the patients in this study began to articulate fond memories of former sacred events, they often did so in familial terms. This was clearly the case when Chaplain Frazier's using a baptism symbol with one of his patients evoked strong positive personal memories of when she was baptized. It was also the case when Chaplain Nathan received similar responses when one of her patients shared strong positive memories of past Christmas and Easter family gatherings. I believe that these patients' ability to connect so powerfully with the symbols was, in effect, their way of doing theology. Despite the limitations placed on them by their disease, they somehow were able to exhibit powerful senses of hope in what, by many, are hopeless situations. Through the case of a pastor with dementia, Kevern suggests that it is not all gloom and doom with many dementia patients, who instead often maintain and embrace theologies of hope.[14] Again, I assert that the chaplains in the study drew out their patients' theologies of hope and in so doing transcended with them. This was all made possible by the fact that the chaplains respected and celebrated their patients as whole, theologically-reflecting persons.

As brought forth in Chapter Two, not only did the patients and chaplains experience mutual transcendence in relationship to their theologically reflecting, but chaplains' senses of personhood were affected by the degree to which they respected the personhoods of their patients. The chaplains in this study were drawn to participating in transcendence, largely because they wanted to find new and effective ways to

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[14] Kevern, "'I Pray that I Will Not Fall,'" 288.

communicate with their patients. As I have suggested, they were able to do so by both acknowledging and respecting their patients' personhoods. However, I, like Stoddart, propose that had they not done so or not done so enough, their personhoods would have been diminished as well. As was previously stated, according to Stoddart,

> The very personhood of the carer is determined by his or her response to the person with dementia. A failure to take time to listen, an over eagerness to correct mistakes, to remove roles, and treat the person as irresponsible diminishes the carer's personhood as much as it does the person with dementia.[15]

Stoddart's work implies that not only are individual caregivers' personhoods diminished as they diminish the personhoods of dementia patients, but such diminishment reflects a failing on the part of individual caregivers. Swinton, however, argues that the problem is more widespread because, with respect to dementia, "Any loss of self relates to a failure of community."[16] Thus, if and when chaplains' behaviors lead to diminishment of their and their patients' personhoods, the failing is not so much on the part of individual chaplains as it is on a broader sense of community, such as groups of individuals responsible for caring for dementia patients in extended-care facilities and patients' families.

For the most part, the chaplains in this study were able to celebrate the personhood of their patients as their patients began to transcend. It was in some of the patients' transcendence that two of the chaplains were able to learn more about their patients' past spiritual experiences, which tended to involve the patients in relation to other people. As Chaplains Frazier and Nathan experienced Terry's and Tina's transcendence with respect to symbols of baptism, Christmas, and Easter, they were able

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[15] Stoddart, "Dementia Care," 11.
[16] Swinton, *Dementia*, 108.

to see their patients in a more human context. They were able to do this despite some of the frustrations they encountered while working with the symbols. Chaplain Garrison, on the other hand, tended to have visits where her patients were less engaged by the symbols.

Swinton also argues that dementia patients do not lose their sense of self.[17] I agree. I believe that what they often lose is their ability to communicate who they have been and still are. I assert that this loss, in many cases, is only temporary. In working with a very confused patient (Gill), through the use of a crucifix, Frazier was able to help paint a picture of a whole person who, though confused about many things, knew enough about himself to know that he had at one time been Catholic. Through the use of Christian symbols, Chaplains Frazier and Nathan were able to demonstrate that these patients knew that much of who they are is fashioned by who they have been in relationship to a community of others. Thus, in the chaplains' celebrating the total personhood of their patients, both they and their patients were communally reflecting and growing into the Imago Dei.

As the chaplains in the study embraced and celebrated the personhood of their patients, they were each able to gain a more holistic appreciation of the value of using Christian symbols with their dementia patients. In essence, they each discovered some non-clinical benefits to using them. This was the case so much so that using this intervention spilled over into their non-clinical personal lives. Chaplain Frazier admitted that before the study began, he generally thought that Christian symbols were "silly." From his location as a child of the sixties, he had early on developed a mild disdain for them. However, at the end of the study, Frazier shared that he had developed a genuine

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[17] Ibid.

appreciation of the value of Christian symbols. As was alluded to earlier, Chaplain Garrison found that using Christian symbols with her dementia patients helped her understand the importance of trying to symbolically connect with the parents of some of her friends and colleagues. Chaplain Nathan likewise discovered that using Christian symbols with dementia patients has increased her ability to communicate with her mother-in-law. She stated that this level of communication is gratifying to both her and her husband.

In this chapter, I have interpreted the behaviors of the chaplains in this study in light of thirteen themes. Chapter Five will provide a brief summary of my research method and findings before drawing some pragmatic conclusions.

CHAPTER 5

The Pragmatic Task: Conclusions

For this study, between March and August of 2014, three chaplains showed Christian symbols to six patients over the course of three visits each. The symbols fell into the following five categories: Jesus' nativity, crucifixion, and resurrection and the sacraments of baptism and the Lord's Supper. The chaplains documented what they did and what they learned in their clinical notes. For the sake of protecting patient privacy, de-identified clinical note summaries were prepared and coded to capture whether or not patients recognized the symbols and whether or not symbol prompting was helpful. Both symbol recognition and symbol prompting later emerged as themes in the findings. These coded clinical note summaries then served as a basis for forming the first round of interview questions. The first set of interviews occurred between May and August 2014.

The goal of the first set of interviews was to gain insights into what chaplains' best practices of using Christian symbols with their dementia patients looked like. The rationale for examining patients' responses to being shown the symbols is that some understanding of the effects on patients of this intervention were deemed necessary in order to gain a contextual understanding of the chaplains' behaviors. A second round of interviews occurred in December 2014. These were aimed at trying to understand both what chaplains' best practices of using Christian symbols with their dementia patients look like and what the chaplains learned from these practices. In analyzing the second set of the chaplains' interview transcripts, various themes emerged related to what the chaplains did and what they learned.

The 13 themes that emerged were as follows: faith identification, sacred stories,

symbol recognition, symbol prompting, expectations, frustration, patience, flexibility, being in the moment, confidence-builder, intimacy, personhood, and non-clinical benefits. These 13 themes were grouped and viewed through the following three lenses: the Christian story and dementia care, ritual and dementia care, and personhood and dementia care.

The themes viewed through the Christian story and dementia care lens were faith identification and sacred stories. The faith identification theme provided a contextual view and understanding of both chaplains' and patients' stories. The sacred stories theme reflected chaplains' ability to connect patients' long-forgotten stories with Biblical ones. The themes viewed through the ritual and dementia care lens were symbol recognition, symbol prompting, expectations, frustration, patience, flexibility, being in the moment, and confidence-builder. The symbol recognition and symbol prompting themes emerged from the first round of interviews. They reflected whether or not patients recognized the symbols shown to them and whether or not symbol prompting was helpful, respectively. The themes of expectations, patience, flexibility, being in the moment, and confidence-builder each reflected factors that both informed how the chaplains practiced using the symbols and what they learned from their practices. The themes of intimacy, personhood, and non-clinical benefits were examined through the lens of personhood and dementia care. Each of these themes provided insights into various discoveries the chaplains made from using Christian symbols with their dementia patients.

Through an analysis of the data, I found that the chaplains who participated in this study were generally able to both promote patient transcendence and experience their own transcendence through their identifications with their own faith traditions and how

their experiences reflected sacred stories. The chaplains also learned that sometimes their patients recognized the symbols shown to them and sometimes they did not. Thus, they discovered a need to help their patients by prompting them with respect to what the symbols mean.

Related to both symbol recognition and symbol prompting, the chaplains found that managing their expectations, being patient, being flexible, and staying in the moment helped ameliorate some of their frustrations in not always connecting with their patients. They, in turn, discovered that as they did these things, their confidence in using this intervention grew. As their confidence in using Christian symbols grew, they also learned that their ability to both promote patient transcendence and experience their own transcendence likewise grew. Similarly, the chaplains generally experienced an increased closeness to their patients when using this intervention, and this tended to be fueled by the degree to which the chaplains embraced and celebrated their patients' personhoods. Finally, the chaplains each realized that using Christian symbols with dementia patients helps them in their non-clinical personal lives.

In some ways, I now end this dissertation where it began by returning to Swinton and Mowat's definition of practical theology and stating it as a question. In essence, to what extent have the hospice chaplains in this study, through the use of Christian symbols with dementia patients, enabled the faithful performance of the gospel while also exploring and taking seriously the complex dynamics of their dementia patients' encounters with God? This question is more of a rhetorical one aimed at raising a conscious awareness among hospice chaplains using Christian symbols with dementia patients of the degree to which they are faithfully helping these marginalized of the

marginalized members of the household of faith increasingly and communally grow into the Imago Dei in new and transformative ways.

While this dissertation has explored the use of various Christian symbols depicting key historical events and sacraments of the Church, I challenge Christian hospice chaplains and the Church alike to extend and broaden their understandings of what these symbols in essence are. I believe broadening understanding of these symbols is necessary in order for hospice chaplains and anyone spiritually caring for dementia patients to increase the likelihood that these children of God will be able to meaningfully connect with the symbols and experience subsequent transcendence. I further believe that spiritually caring for dementia patients using Christian symbols is a reminder that these Christians do not exist in vacuums.

Thus, I believe it behooves hospice chaplains to view their dementia patients as existing in holistic contexts. They, though limited in their cognitive capabilities, are still able to connect on spiritual levels. Hospice chaplains, who are both aware and grounded in broad understandings of Christian symbolism, are better equipped to meaningfully connect with dementia patients because of the innate transcendent power of symbols. Furthermore, such a broadened notion of symbols widens chaplains' symbol toolkit, giving them deeper understandings and stronger appreciations of the value of such interventions.

I contend that it remains unclear what the full potential of using symbols with dementia patients is. If hospice chaplains are committed to continually exploring new ways to symbolically connect with their dementia patients in holistic contexts, I claim they are better able to enable the faithful performance of the gospel while also exploring

and taking seriously the complex dynamics of dementia patients' encounters with God. In doing so, I believe they are ultimately helping these patients transcend or reach a state of awareness whereby they are able to reflect anew the image of God. Doing anything less is akin to looking at them as if they are one-dimensional characters in the unfolding human drama. Throughout this dissertation, I have made every attempt to present dementia patients as full-fledged children of God with rich pasts and possibility-laden presents that all have and continually reflect the Imago Dei.

I contend that a broadened understanding of Christian symbols can be achieved through the following four lenses that I have devised, or combinations of them: (1) object-oriented versus human figure-oriented; (2) personal versus public; (3) local versus universal; and (4) ritual-oriented versus non-ritual-oriented. Each of the symbols in this study can be viewed through one or more of these lenses.

With respect to object-oriented versus human figure-oriented Christian symbols, I argue that effective Christian symbols are not only those associated with depictions of sacred physical objects or the objects themselves, such as rosaries, Bibles, sacred pictures, crucifixes, and crosses. Object-oriented Christian symbols are not the only ones that are efficacious in promoting patient transcendence. Depictions of clergy and clergy themselves can symbolically lead to patient transcendence, as can depictions of other representatives of the Church, such as Jesus, the Twelve Disciples, and the Pope.

Personal Christian symbols are symbols that dementia patients actually own themselves, such as those listed above. Public Christian symbols are those that do not belong to individuals, which could be the same as the ones previously mentioned or different ones. Local Christian symbols are those associated with particular congregations.

These can take the form of photos of church events (such as picnics and worship services), church newsletters, and bulletins. Among the set of universal Christian symbols are those used in this research depicting the birth, death, and resurrection of Jesus as well as those depicting baptism and communion. Universal symbols might also be more generic symbols, such as those depicting heaven and angels.

The fourth symbolic lens is ritual-oriented versus non-ritual-oriented symbols. In addition to the rituals of the sacraments of baptism and communion used in this study, other Christian ritual depictions and the rituals themselves might be considered. These other Christian rituals include prayer, which may be symbolized by hands clasped in prayer or a believer knelt in prayer. Christian gestures that are hard to represent through static pictures, such as someone making the sign of the cross, can readily be done by spiritual caregivers. It should be noted that the actual sacraments of baptism and communion studied in this dissertation are, in and of themselves, ritual-oriented in nature.

To the extent that local churches are themselves Christian symbols, I encourage hospice chaplains to collaborate and partner with them to develop specific ministries that can holistically foster dementia patients' transcendence and do so both faithfully and responsibly. More will be said about this later. From my locations as both a hospice chaplain and an associate pastor at a local AME church, I believe many, if not most, Christian congregations have a lot of work to do in order to use their symbolic power to meaningfully promote dementia patients' transcendence. First of all, my congregation does not have any ministries to care for people with dementia. The net effect amounts to an even further marginalizing of the already marginalized. As far as I am concerned, our congregation does not recognize the needs of this segment of the Church. One question

that might be asked is, "Why not?"

I believe the answer to this question lies in the reality that people with advanced dementia are not only often forgotten, but they are viewed with fear, embarrassment, and shame. Just as our overall culture denies death, it also denies that dementia is a real issue for both individuals and families, many whom have given their time, talents, and financial resources for the good of their congregations. This is not only a problem within our overall culture, but in my local congregation as well. It is as if these believers are invisible. I will not go so far as to say that they are not loved. However, if the corporate care they are lacking is any indication, one has to question the depths of the love church members claim to have for them. Another reason churches may not be substantively caring for these children of God is that people are afraid that they, too, may one day develop this disease and are concerned about whether or not they will be forgotten and marginalized as well. Maybe people are subscribing to an "out of sight, out of mind" mentality. If this is so, are they doing even more damage by putting people with dementia in nursing homes without fully exhausting viable alternatives? Perhaps, underneath all of the fear, embarrassment, and shame persons with dementia call up in others, people simply do not know how to address the fact that within their communities there are individuals and families who are struggling with how to lead meaningful, God-honoring lives amidst the turmoil of this dreaded disease.

At present, I wonder if church members with dementia are content to simply step down from their positions within the church for the sake of progress and moving the church forward? Is my congregation really progressing and moving forward if it does not find other ways for members with dementia to meaningfully approach transcendence? I

believe that Christian churches are required to find alternative ways to minister to this forsaken segment of their congregations. Maybe these elders of the church have forgotten a lot. However, I sense they have not, for one moment, forgotten what the difference between feeling loved or not loved is like.

In short, what my congregation needs to do is find meaningful ways to use its symbolic power to help guide its individual members with dementia toward transcendence. If we can do this, we will not only be helping these members reflect and communally grow into the Imago Dei, but we ourselves will be corporately doing likewise. What follows are some suggestions or model overviews for my local congregation and others like it. First, I will paint a picture of my congregation with a relatively broad brush. It is an inner city congregation in a predominantly African-American neighborhood that used to be mostly Caucasian, up until the middle of the last century. It is considered to be the most stable and the strongest church in the local district and one of the strongest ones in the annual conference and larger episcopal district. It has approximately 600 members on its rolls. A little less than half that number is likely to show up on any given Sunday, excluding special occasions. The average member of this church is middle to upper middle class and approximately between the ages of 40 and 70. There are a significant number of members who are below the age of 21. Church growth is relatively slow in this congregation. However, with a new, high-energy, relatively young seasoned pastor, the membership numbers are expected to quickly climb. Over the last year, the pastor has been preparing the congregation for change, and it is gradually witnessing some significant changes, primarily in the design of the worship services, music, and some technology enhancements currently being considered.

I believe that at the core of any church's ministry model designed to foster dementia patients' transcendence is a commitment to celebrating these often longstanding members of the worshipping community. In my congregation, we can borrow from some of our Black History Month events. Among them are story-sharing activities. Through these activities, each of the most senior members of the congregation who are able to tell "my story," however they want to frame it, to the rest of the congregation in after-service programs. Of course, food and décor add to the festiveness of these occasions. I believe similar programs adjusted for dementia patients' cognitive declines can significantly encourage both their transcendence and that of the congregation's.

One way of adjusting story-sharing activities to the needs and capabilities of dementia patients is to conduct them in smaller and more intimate settings. Perhaps fellowship halls can be temporarily arranged into several clusters or stations where groups of no more than five parishioners sit with individuals with dementia and listen to them "talk about the past." Parishioners would need to be trained on how to "be in the moment" with those with dementia. They would need to learn how to listen without correcting or judging and how to incorporate play into the settings. They would also need to learn how to listen for the underlying feelings associated with some of the historical events shared by the elders. When the elders experience and exhibit confusion, parishioners need to learn how to play along. If they do so patiently, I believe eventually enough of the motivating core truth of the story will emerge. There would need to be trained facilitators, such as chaplains or loved ones, whom the elders are comfortable with and trust. These persons would then attempt to engage the elders on topics or stories from their pasts. Significant family- or work-related events could possibly be used as

memory starters. The parishioners surrounding these elders would simply listen, observe, and learn so as not to over-stimulate the elders. Care should be taken by the facilitators of such ministries to ensure that each small group spans different generations. Following elders' story-sharing times there should be small-group discussions of what the group members learned. Any questions the group members want to ask the elders should be done so through the facilitators. This intergenerational program is but one way local parishes can celebrate their elders with dementia.

Church members engaging in sick and shut-in ministries should receive specific training on how to communicate with elders living with dementia. Perhaps they could also be professionally trained in how to use Christian symbols to communicate with them. Mostly, however, the members of these ministry teams need to be mindful of the fact that they represent a powerful symbol, one that promotes transcendence and is called "the Church," with both a lower case and a capital *c*.

Local churches need to be aware of the fact that all Christians need educational instruction if they are to mature in their faith. Individuals living with dementia are no less in need of such instruction. However, how does a church teach such elders and foster transcendence? Instead of ignoring their educational needs, churches could use an adjusted form of Godly Play to teach or remind persons with dementia of important Bible figures or lessons. Essentially, this form of Godly Play would use various means of storytelling, including puppets and drawings. The local church committed to fostering transcendence among its elders with dementia should be cognizant of the fact that there are various stages or levels of dementia. In any congregation, there are likely to be individuals at various stages of the disease process. Therefore, it is imperative that any

such educational interventions should be customized to the dementia stages found within the congregation.

I believe a local church's commitment to its members living with dementia should tap into the rich pasts of these individuals. The church needs to be keenly aware of the fact that these individuals have not always had dementia. They are often still spouses, parents, grandparents, great-grandparents, uncles, aunts, brothers, sisters, and friends to others. They have worked in a variety of settings requiring particular sets of skills and acumen. Perhaps they were doctors or nurses. Perhaps they were schoolteachers or pastors. Perhaps they worked in the private sector or the public sector. Perhaps they worked with their hands or perhaps they worked with their minds. The work lives of people with dementia have formed a strong basis for a key part of their unique identities throughout their lives. Just because they can no longer perform and carry out these activities and responsibilities does not mean they are completely forgotten. I once witnessed a dementia patient of mine who was approaching 100 sitting alone at a table with papers and technical books. He was touching them and moving them around. While this behavior might have appeared odd to some, it was totally appropriate given the fact that he was a scientist most of his adult life. I also learned that he had written a personal memoir when he was well into his nineties.

Just as their work lives have played large roles in shaping and forming the identities of individuals with dementia, their family lives have also had a major influence on their current behaviors. For example, it is not uncommon to find women with dementia holding and carrying baby dolls close to their chests in many nursing homes. Their role as nurturers and mothers continues to shape and form their current and

emerging identities. Church ministries that are effective in fostering dementia patients' transcendence are thus committed to celebrating these rich histories. One way they can accomplish this, based on the above scenarios, is to pair individuals with dementia with younger dementia-free parishioners who share the same occupations. Similarly, new or younger mothers can be paired with some of the women with dementia as they both caress and hold the baby dolls in their arms. These are just a couple ways that congregations can, through occupational and family roles, both honor and celebrate their members living with dementia.

Congregations committed to holistically spiritually caring for their members living with dementia recognize that in order to provide sufficient spiritual care for these children of God, they should likewise, at some level, care for their minds and bodies. When Jesus healed the Gerasene man in the Gospel of Mark, he did so in such a way that the man was ultimately found "clothed and in his right mind" (Mark 5:15). The implication is that, along with being spiritually healed, both the man's mind and body were likewise healed. Thus, holistically speaking, congregations committed to the spiritual care of their elders with dementia should also provide some opportunities for them to exercise, whether it be through Tai chi, dance, or some other means.

I cannot overstate the importance of incorporating intergenerational relationships into church ministries designed to spiritually care for elders with dementia. Just as the local church and universal Church have symbolic power to promote dementia patients' transcendence, so too does the laity. After all, the church consists of both clergy and laity. I assert that the collective symbolic power of congregations is the sum total of the symbolic power residing in their individual members. With this in mind, it behooves

local congregations to instill in their parishioners, beginning in childhood, the symbolic power and presence they possess in caring for dementia patients. Local congregations thus need all of their ministries to buy in to this idea. In doing so, they are helping congregations to enhance their collective abilities to use their symbolic power to both foster dementia patients' transcendence and their own.

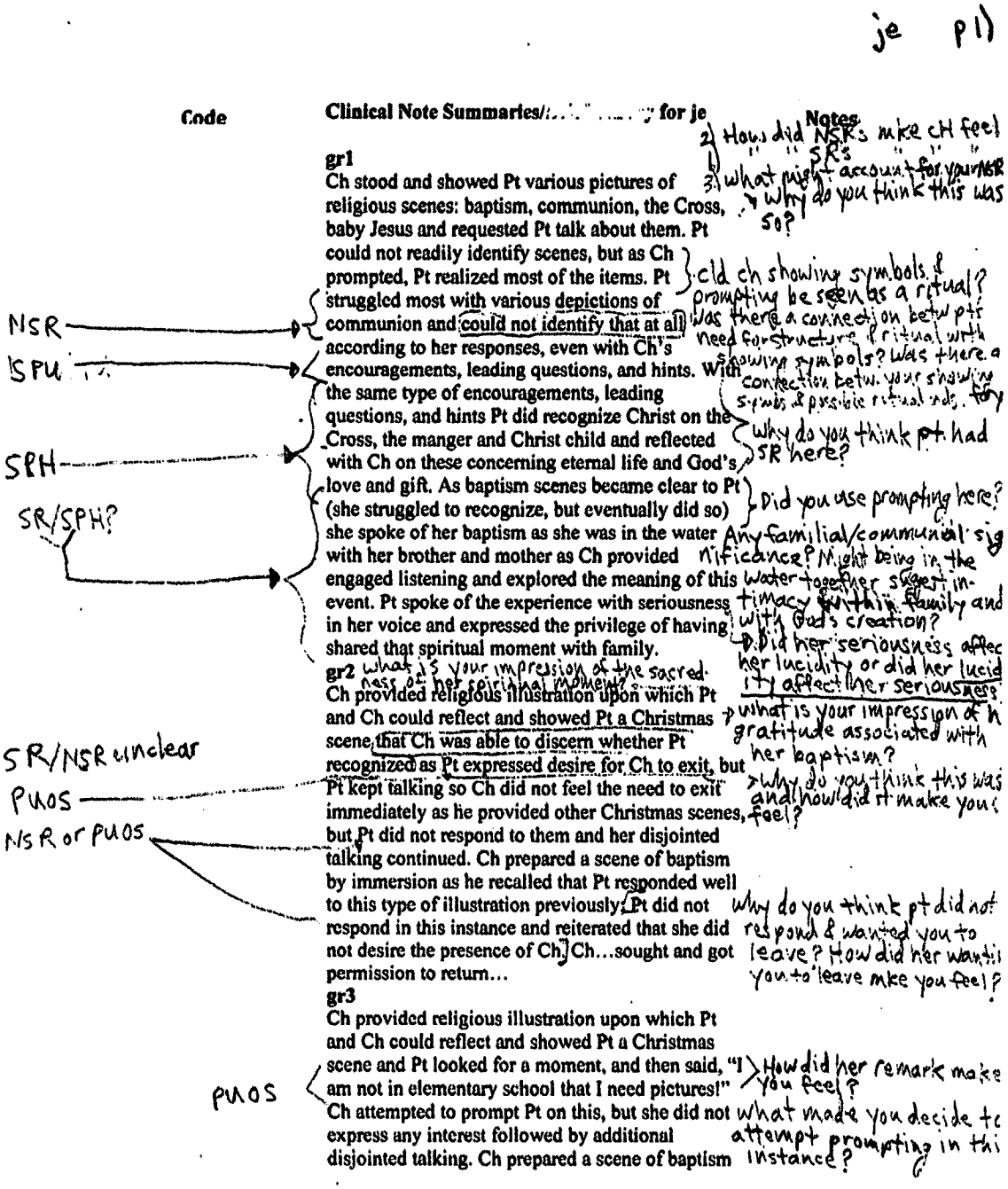
It has been argued throughout this dissertation that as dementia patients transcend, they both reflect and grow into the image of God in new ways. I believe as dementia patients grow into the Imago Dei, their transcendence ultimately has the power to transform shame into dignity, dehumanization into personhood, fear into assurance, ignorance into knowledge, foolishness into wisdom, misunderstanding into understanding, denial into acceptance, confusion into clarity, sadness into joy, anxiety into peace, despair into hope, hardheartedness into forgiveness, darkness into light, hate into love, and death into life.

APPENDIX A

Sample Clinical Note Summary

The clinical note summaries used initials for both the chaplains and patients. The following key gives the de-identified names that correspond to the initials in this sample:

Chaplain JE = Chaplain Frazier
Patient GR = Patient Terry
Patient WM = Patient Gill



by immersion as he recalled that Pt responded well to this type of illustration previously; Pt repeated the reference to not being in elementary school and showed some anger; Ch acknowledged this and did not repeat any religious illustrations as he listened to Pt as she spoke of the goodness of God…Ch sought and got permission to return…

wm1

Ch showed Pt different scenes of Biblical and church events; Pt answered that he knew that there were religious events taking place recognizing baptism, but could not identify a typical picture of Jesus and could not gather that this person was connected to religious events. Pt did specifically mention that he recognized things connected with the Catholic church. Ch expressed surprise in light of the fact that the Pt had never mentioned Catholicism previously, but affirmed him in his historical religious experience. Pt acknowledged that he had been Catholic, but shared that he had not attended in years and had forgotten a great deal.

wm2

Ch showed Pt religious artifacts and asked Pt what he could glean from them. Even as Ch prompted, Pt could not relate the religious context. It happened that the word "Baptism" appeared on an artifact and Pt connected with this, recalling that he had been baptized. Ch inquired about this: did Pt remember? Were Pt's parents there? Was Pt a child? (all responses were "No.") Pt referred to his Catholic background, but could recall nothing else about it as Ch explored: Pt did not remember and did not recognize Communion, knew that the Crucifix was Catholic and related that it was a priest on the Cross and even though the word "Christmas" appeared on an artifact, Pt did not appear to connect. All religious references were associated to a priest and did help Pt recall his Catholicism without any details available to the memory of Pt as Ch affirmed Pt in his recollection of his religious history.

wm3

Ch showed Pt religious aritfacts concerning Catholic communion and asked Pt what he could glean from them. Even as Ch prompted about "priests and the Host," Pt could not relate to the religious context. Ch presented a more specific

je p3)

NSR/SFU?
SR

SR

picture and Pt could not connect with these and as Ch explored Pt's religious history Pt related that he could remember only that he had been Catholic many years ago. Ch attempted to prompt Pt with various artifacts of Christmas, both religious and family types. Pt struggled with recognizing the religious scenes, but did conclude after seeing several views that the baby was Jesus. Pt readily recognized family scenes (tree, lights, gifts) but as Ch asked of either childhood or his experiences with children or grandchildren, Pt had no recollections and Christmas had no meaning to him.

Even though Pt did not have a specific symbol response to convey the symbol did evoke several [illegible] response [illegible] Did Pt no longer believe he was Catholic? If s why might this be? Might symbols w/ family more powerful/general than specific [illegible] ?

APPENDIX B

Interview Transcript Excerpts

Excerpt from Chaplain Frazier's First Interview

00:01 Speaker 1: This is an interview with Chaplain Frazier on 9/12/14. We're gonna discuss patients Terry and Gill. This is in fulfillment of a dissertation entitled... Basically, on chaplains using Christian symbols with dementia patients and their responses. Let's begin.

[background conversation]

00:32 S1: I'm looking here in Terry 1. First of all, I wanna say thanks for your participation. When you were with Terry on that first visit, when you did get a symbol response, what... Any feelings... Any particular feelings, how did that make you feel?

00:51 Speaker 2: When I did get a response?

00:52 S1: When you did.

00:54 S2: Yeah, I felt relieved, because I didn't think she was gonna connect at all, and when she did and it was such a good reaction as far as my evaluation, that I felt relieved and happy. Both, that it meant so much to her and second, that she reacted at all, because I didn't think it was gonna happen.

01:21 S1: Why did you feel that? Why did you think that wasn't gonna happen?

01:24 S2: Well, because she wasn't getting anything. And I was actually getting mad at her...

[chuckle]

01:33 S2: 'Cause this was my first experience and I thought to myself, "What could be clearer than Christmas or Communion and baptism?" whatever I used. I was like, "This is crystal clear, woman, why aren't you getting it?" It actually took me several attempts with both patients to get over that, that feeling, and to understand. And a second thing that, when I first went through it, I didn't prompt anybody and I learned that I needed to prompt and that helped a great deal. But I was really upset.

02:25 S1: Kinda like frustrated, you mean?

02:26 S2: Oh, yeah, frustrated and like, "What could be clearer than this?" But it obviously wasn't.

Excerpt from Chaplain Nathan's Second Interview

00:01 Speaker 1: This is an interview with Chaplain Nathan on Wednesday, December 10th, at about 11:40 in the morning. Hey, Chaplain Nathan.

00:15 Speaker 2: Hey, how are you doing?

00:16 S1: Good to see you. Good to see you again. This is a follow-up interview to some interviews that were done back in the fall. Well, the first question I have is a little different than what I had stated earlier. Instead of what Christian symbols, I just wanted to know, overall from what you recall, which symbol, which one symbol worked the best for you? Just tell me your general impression.

00:45 S2: I think the symbol that worked the best for my people was the communion, the one with the loaf and the cup.

00:57 S1: Okay.

00:58 S2: It seemed like most of the time, the person had more to say than just about communion. They talked about that, but it led into things about family gatherings, meals, special times together, so I thought that was really effective.

01:15 S1: Good, good, Yeah, I remember that from you from the first round of interviews, from reading some of your transcripts. Well, that's good to know. So that would be the best one, the most effective one for you. Okay, if you were to work with these symbols again, with your patients, same patients or maybe even different patients who have dementia, what are some of the things that you might do differently, based on what you learned from the first time around?

01:46 S2: I think I would add some very common pictures, maybe environment, outside pictures, animal pictures, just to get them relaxed at looking at the pictures and in responding and then go into these symbols that I think more conversation will occur.

02:05 S1: Okay.

02:05 S1: Even though I had good response, but I think that would even make it better. The reason I think I would do that is I had one patient that I did that at the end, Then, I still had a picture up of the... Anyway, she went back to some of the pictures and wanted me to bring them up. It just kept the conversation going. We'd already gone to the religious symbols, the Christian symbols.

02:32 S1: Sure, sure. Okay so maybe trying that upfront, to kind of set the stage and to open up a little bit.

02:37 S2: Yes. Yes.

APPENDIX C

Informed Consent Form for Participation in Study

Project Title: *Hospice Chaplains Using Christian Symbols with Christian End-Stage Dementia Patients: A Case Study*

Sponsoring Institution: Claremont School of Theology

Statement of Purpose of Research: This research is intended to gain and present an understanding of how and why hospice chaplains use Christian symbols in ritually helping dementia patients transcend their finite existence.

Duration of Participation: The case study will span 6 months.

Procedures: The data collected for this case study will be obtained through the use of the following methods and procedures – de-identified chaplain clinical notes, chaplain interviews, and one brief survey.

Description of Risks: The risks to the chaplain participants are that they could experience frustration in trying to communicate with their patients. They could also experience disappointment in not receiving a desired patient response to the Christian symbols.

Measures to Protect Confidentiality: The privacy risk to both the patients and chaplains involved will be kept to a minimal level as the chaplains protect patients' medical records and other health information per HIPAA guidelines. Chaplains will conduct their visits either in patient rooms, areas within care facilities, or within patient homes. Chaplains will also do their clinical documentation in private locations. Care will be taken by the chaplains to use the third person in writing their notes. The chaplains will then cut and paste only the anonymous portions of the relevant sections of each patient's clinical note into an anonymous clinical note summary.

The *brief survey* questions and the interview questions will be the same. Both chaplain and patient identification codes will be used to identify the survey forms. The *interviews* will be conducted in the Hospice of Dayton chapel since this is generally a very private location through the use of voice recordings on the researcher's password protected smart phone. Each anonymous clinical note summary, interview transcript, and survey form will be stored in a secure locked file box. Within four months of the completion of the case study, all clinical note summaries, interview transcripts, and survey forms will be shred. Likewise, the chaplain interview recordings will be deleted within the same time frame.

Participation: Participation in this case study by both chaplains and patients is completely voluntary. Either party is free to withdraw from the study without penalty. All withdrawals should be done in writing by either the chaplain or patient's legal guardian. The document should be dated and signed.

Contact for Research Questions: Participant's questions should be directed to either Kevin Wardlaw, the researcher, or Dr. Sam Lee, the research advisor. Kevin Wardlaw can be reached at kevin.wardlaw@yahoo.com or via the contact information provided below, and Dr. Lee can be reached at slee@cst.edu.

Procedure for Participants to Obtain Copies of Paperwork Regarding Their Consent: Requests for such information should be done in writing and addressed to the researcher.

Investigator Contact Information – Chaplain Kevin Wardlaw, M.Div., 111 Grafton Avenue, #705, Dayton, OH 45406; 937-580-7133

Acting Chairperson of the Claremont Lincoln Institutional Review Board – Dr. Thomas Phillips, Dean of Library and Information Services, Claremont School of Theology/Claremont Lincoln University, 1325 N. College Ave., Claremont, CA 91711; 909-447-2512

Dean of Faculty at Claremont Lincoln University – Dr. Sheryl Kujawa-Holbrook, Dean's Office, Claremont Lincoln University, 1325 N. College Ave., Claremont, CA 91711; 909-447-2520

Certificate of Consent

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

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